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**From the classroom to the clinic
Ethics education and general practice**

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From the classroom to the clinic: Ethics education and general practice

Thesis submitted by
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King's College London

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Abstract of the thesis

This thesis is a qualitative study of ethics education as experienced by general practitioners in mainland Britain. It draws upon interviews and documents as well as observations and reflections from encounters in the field. Ethics is conceived of as a kind of knowledge and ethics education is seen as involving translational processes shaped by various social forces and tensions. The data analysis is organised according to three concepts outlined by Bernstein: curriculum, pedagogy and evaluation. These broadly map to academia, education and practice, and the purposive sample reflects participants with involvements in these three domains. Ethnographic, phenomenological, and grounded theories are key influences on the method for selecting and organising the empirical data. The findings chapters look at the determination and production of the broad curriculum (chapter 4); the 'transmission', or the delivery and reception of, the curriculum (chapter 5); the assessment of ethics education (chapter 6); the ways in which ethical issues are identified and negotiated in practice (chapter 7); and key substantive issues that arise in practice – confidentiality, abortion, payment for performance and resource allocation – which enables an exploration of the negotiation of ethical issues in practice (chapters 8 and 9). The concluding chapter pulls the threads together. Societal forces and tensions are present when curricula are conceived, when knowledge and skills are taught and when GPs attempt to integrate learning into their daily practice. Having understood these forces and tensions better we can conceive better of how to make improvements to ethics education and assessment. The overall aim is to improve the reflexivity of ethics education. Many of ethical shortcomings of doctors have historically been linked to hidden curricula, features of practice and the practice environment that have been unseen or ignored by

teachers or learners. Knowing more about these features and about the translational processes, that shape the experiences and enactments of GP ethics, provides the potential ability to adjust for their influence.

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2. How do GPs manage ethical issues in their professional lives?	343
3. How is ethics-education produced for and delivered in General Practice?	344
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Chapter 1: Introduction

Introduction

This thesis is a qualitative study of ethics education as experienced by general practitioners (GPs) on the British mainland. It draws upon interviews, documents and, in places, my own observations and reflections on encounters in the field. The broad aim of the study is to understand, and support collective reflexivity about, the multiple forces that shape GP ethics education. General practice is the largest medical speciality – there are more GPs than any other kind of fully qualified doctor in the UK. And yet bioethics scholarship (both theoretical and empirical) tends to focus more on hospital medicine and biomedical research. One reason for this is that it is in hospital and research medicine where the dramatic dilemmas and the new ethical questions are seen to arise. However, the study of ethics in general practice (Family medicine or equivalent internationally) is itself of profound importance. There is also no good reason why dramatic dilemmas might not occur in the general practice setting. For example many of the court cases which discuss ethical issues at the end of life (e.g. euthanasia and the doctrine of double effect) have involved GPs (Huxtable, 2007). Furthermore the setting itself may predispose clinical practice to certain types of ethical issue –for example, the fact that patients generally present with more minor complaints in community rather than hospital setting may give rise to more complicated negotiations of power between patient and GP (Brody, 1992). And the prolonged exposure some GPs and patients have to one another over many consultations, sometimes over many years, can generate a more complicated kind of respect for patient autonomy than is seen in the acute setting (Doyal and Sokol, 2009, Doyal, 1999). In addition, departments of general practice have fostered the teaching of ethics to

medical students in a number of universities. In the course of planning this study I became aware of accounts of such initiatives in London at St Thomas's (Zander, 1989a, Zander, 1989b) and Edinburgh's (Boyd, 1987) medical schools.

So why study the phenomenon of ethics education in UK mainland general practice? Reasons why research questions are identified for conducting qualitative research in medical ethics include:

- Personal or professional experiences
- Review of the literature
- A specific assignment or charge
- Gaps identified in previous work
- A perception that previous understanding is lacking (Chandros-Hull et al., 2001)

All of these factors have relevance in this study. Personal and professional experiences, in particular, have played a large role in the shaping of this study – a factor that I discuss at length in the section on reflexivity in the methods chapter. As an initially amateur ethicist attempting to professionalise my own interests in the context of general practice, I noted the relative lack of literature and of perceived support both for educators and practitioners. The study asks how ethics translates between theory and practice for GPs in Britain. I have chosen to focus on ethics as knowledge, and therefore on education as the process of translation. There is relatively little literature on how ethical issues are recognised and negotiated in General Practice, as acknowledged by Bowman and Spicer:

...research into or about the ethical terrain in primary healthcare would be of inestimable value for the future. The traditional model of ethics analysis is philosophical and reasoned. In applied ethics, the methods of, for example, sociological research have added to knowledge about how

moral theory is interpreted and used. We know little about how clinicians in primary care derive their moral professional behaviours and why, and perhaps we should (Bowman and Spicer, 2007a).

There are even fewer accounts of ethics teaching in the context of UK general practice, and these tend to be found more recently in medical education journals than medical ethics journals.

This study was conducted during a period of change. During the period when I gathered data the newly-introduced curriculum for General Practice training was completely revised and restructured. A system of compulsory assessed continuing professional development was introduced for all doctors (revalidation). However that is not to say that change itself was a new phenomenon. Participants brought with them experience of how things had been different over the course of their own lives and professional careers. Some had been in practice for decades and others had begun their professional careers abroad. In addition, there were widely accepted societal changes, which meant that even a snapshot view of ethics education might yield data and insights that were not possible a decade previously. The Royal College of General Practitioners' (RCGP) manual for GP-trainers and GP-educators suggests that the following changes in society at large may be affecting the doctor-patient relationship (Deighan, 2008):

- Rise of consumerism in medicine
- Emphasis on patient autonomy
- Changing status of women in society
- The rise of a disabled culture of affirmative action and pride
- Attacks on professional self regulation
- Increasingly litigious environment
- Multiculturalism

- Social concerns about assault and violence towards women
- Holistic and alternative health movement
- Change in the status of all professions in society
- Decline of role of medicine and expansion in role of other professionals
- Increased use of technology
- Shift of care from hospital to community
- European working time [regulations]
- Increased hospital liability for doctor's care
- Administrative- containment of medical costs
- Increased emphasis on informed consent
- Increased attention to prevention and patient education
- [Increased] social acceptance of physician-assisted suicide
- Doctor's role as trustee regarding disability benefits

The above list is not exhaustive. It is reproduced in its entirety to demonstrate professional awareness that changes in society can affect the consultation as well as other GP roles outside the consultation. Many if not all of the above items also connect in some way with issues that could be easily classed as ethical. In this thesis I have set out to study what UK GPs see as ethics, what educators teach as ethics and what academics frame as ethical discussion, guidance or proposed policy. My definition of ethics is a loose one by necessity. My participants used words like ethical and moral interchangeably. I came across references to philosophical methods of ethical analysis, professional ethical guidelines and legal requirements as well as professional etiquette. I took my definition from the participants as those things that they considered to be ethical. As well being problematic for me as a

researcher this is also problematic for ethics education in general practice and medicine more broadly. It is discussed in greater depth in chapter 4 and the conclusion.

Summary of Research Questions

I began this study with the following research questions:

1. What issues and questions do general practitioners consider are ethical and how are these recognised?
2. How do GPs manage ethical issues in their professional lives?
3. How is ethics-education produced for and delivered in General Practice?
4. How do the recognition and management of ethical aspects of practice inter-relate with ethics education in general practice.

I used Bernstein's conceptions of curriculum, pedagogy and evaluation to sort my data in the context of education (Bernstein, 1971). Bernstein's categorization of educational activity usefully mapped on to three areas that I sought to explore the connections between, namely academia, education and practice. The chapters are set out as curriculum (how is ethics produced for the education of GPs?), pedagogy (how is ethics learned by and taught to GPs?) and evaluation (How are GPs' enactments of ethics 'tested', either in formal assessments or in practice?).

Structure of the Thesis

In the rest of this chapter I outline what each subsequent chapter will contribute to the thesis. Chapters 2 and 3 outline my theoretical starting points and my methodological approach to the empirical component of this thesis. In the empirical sections of this thesis, I draw upon the responses of three groups of actors who 'do ethics' in similar but non-identical ways and who interact with one another: GP-trainees in vocational training and 'jobbing' GPs who are neither involved in academia nor education, trainers and educators (one of whom was not a

GP), and a small group of GPs who frame and conceptualise ethics in ways that shape the experiences of the other two groups.

Chapter 2: A theoretical approach to the study of ethics education in general practice

In chapter 2 I describe the theoretical underpinnings of the thesis. For the purpose of the thesis ethics is treated as a form of knowledge rather than as the regulation of a professional group. However, the regulatory properties of ethics education cannot be dismissed, and contribute to the interest in the ethics education of clinicians by a variety of stakeholders.

The interrelation of agency and structures rather than an emphasis on one or the other is implicit in this study – one that attempts to analyse both the production and the experience of ethics education. I have based this study on the assumption that both social structures and the personal agency of the participants are relevant, but that the ability to influence social forces rather than be influence by them is present in a minority of individuals and situations.

Consequently, an initial way of understanding structures is useful: I use the analogy of developing an understanding of a sport by watching it played.

The chapter considers curriculum, pedagogy and evaluation (Bernstein, 1971) as messaging systems for the translation of ethics education between classroom and clinic or between argument and action. I consider two other attempts to describe messaging systems (from the sociology of science and biopolitics). The messaging system is used in this thesis as a way to organise data analysis – as I observe, the categories of curriculum, pedagogy and evaluation broadly map on to three categories of participation in the qualitative empirical data, namely academia, education, and practice.

I discuss the social forces that participants from the ethics education of general practice might be influenced by and (less frequently) influence. 'Boundary work' - a concept from the sociology of (usually) scientific knowledge - is presented as a useful sensitising concept.

The chapter concludes with the idea that the study of ethics education can be seen as a study of translational processes (Cribb, 2010). Whilst it is beyond the scope of this thesis to identify which styles of argument, or which moral arguments, are ethically 'more right' or 'more true' – this study can shine some light on how ethics as an educational subject is subjected to social forces, and is potentially used by participants to influence similar forces.

Chapter 3: Methods

Chapter 3 describes my approach to the study of ethics education in general practice. The choice of a qualitative method flows from the theoretical ideas in the preceding chapter. 'How' and 'what' questions are best answered with a qualitative approach. Methodological influences on this thesis are discussed: ethnographic, phenomenological, and grounded theories are key influences on the method for selecting and organising the empirical data. Prior to and during the study I have lived amongst the participants. I have also sought to give them voice and to capture their ideas and definitions rather than to evaluate them against a pre-ordained standard.

I do not seek statistical representativeness, being aware both of theoretical and empirical arguments about sample size and about how randomisation of participants can be self-defeating. In particular I am conscious of the phenomenon of self-selection, given that there were no compelling incentives to participate. Recruitment of participants involved striking a balance between theoretical and convenience sample. For example, I focused on some GPs

involved in ethics education -who see themselves as a small select group; but I also included participants who might bring particular perspectives or experiences, such as participation in rural practice.

The analysis of interviews is described as thematic analysis with a modified grounded theory influence. The analysis of initial interviews shaped subsequent selections of, as well as discussions with, participants.

Reliability and validity – the ways in which the results may be considered to be authentic and relevant- are concerns that qualitative researchers must consider. Throughout the project I have remained in contact with the majority of participants, as well as showcasing methodological ideas and emerging themes in academic and educational fora. This has allowed me to informally ‘check’ emerging ideas, not only with participants but with a wider representative group of academics, educators and GPs.

Research ethics, a mandatory feature of all research projects that involve human participants, are discussed. The ethical concerns in this study, indeed in any qualitative study involving practitioners’ descriptions of practice are analogous to some of the issues that can shape ethics education – for example, in terms of patient consent and anxiety over possible censure of ‘substandard’ practitioners.

Reflexivity is a recurring theme throughout the thesis. Being an active participant in the field that I was studying, carried with it strengths and weaknesses, opportunities and threats. I conclude the chapter with reflections on the researcher in relation to the field: this study raises key issues in terms of reflexivity and research ethics that are of relevance to similar future studies, as well as other activities such as workplace-based assessment of current and future GPs.

Chapter 4: General Practice and the foundations of the ethics curriculum

In chapter four I examine the curricular aspects of general practice ethics education. I take an expanded view of curriculum as the knowledge that is tested in assessments and may be enacted in practice. The ethical aspects of the curriculum are shaped by undergraduate teaching, and by the GMC code of practice, but also by academic and professional consensuses. All of these sources are peopled by clinicians and scholars who are subject to social forces. I begin the chapter largely considering literature and published accounts but in the latter parts of the chapter participant data is also used to illustrate my analysis.

New undergraduate medical curricula emphasise attitudes, values and other aspects of professional life which have previously been considered to be part of the hidden curriculum. This mirrors the curriculum for general practitioner training. However the tension between what Bernstein calls strongly framed collections and more weakly framed integrated curricula is evident in both the literature concerning undergraduate and postgraduate ethics education. Taught separately ethics suffers from many of the shortcomings of other disciplines, but integrated it may vanish as a result of 'dilution' in the timetable.

One of the forces shaping the ethics curriculum is how general practitioners define themselves as a profession. Many of the ethical dilemmas that form part of an undergraduate academic curriculum originate in hospital medicine. But generalism entails different and sometimes subtler issues and a broader set of possibilities which are harder to define. Moreover the ethic espoused in professional definitions of general practice arguably influences the ethics curriculum for GPs and generates its own set of ethical concerns.

The foundations of the syllabus have for some decades been a combination of ethical theory and predetermined ethical issues. The chapter includes a discussion of how certain ethical approaches are explicit (e.g. Beauchamp and Childress' principles) and others are omnipresent and implicit (e.g. utilitarianism). I also consider whether postgraduates require a nuanced ethics curriculum founded on a better defined body of knowledge and community of scholars.

Chapter 5: Ethics education in general practice – formative encounters

If chapter 4 is about the determination of, and production of, appropriate ethical knowledge, skills, and attitudes for GPs, chapter 5 is about the 'transmission' of these things i.e. the ways in which ethics education is delivered and received. The phenomenon of ethics education, considered separately here from the content of the curriculum or the ways in which that knowledge is enacted outside the classroom, matches broadly to Bernstein's concept of pedagogy. Participants' experiences of ethics education, whether as learners or teachers, are considered in terms of a variety of educational activities that are relevant to a career in general practice. A loose narrative approach is taken, based on the concept of medical education as a long apprenticeship. Undergraduate and postgraduate experiences are examined separately, and some attention is given to ethics education pre-medical school. The key dichotomy exposed here is between undergraduate and postgraduate experiences. Ethics education is clearly formally embedded in undergraduate UK education, but nowhere near as prominent in participants' postgraduate training experiences.

Chapter 6: Ethical encounters in Evaluation

Chapters 6-8 are about how ethical knowledge is enacted by GPs. Chapter 6 is about formal assessments over the potential span of a GP's medical career. These were particularly exemplified by the many educational assessments that lead to career advancement, whether this means getting into medical school or qualifying as a GP. Moreover, they do not end once a GP has qualified, but recur every time that a GP's knowledge skills and education come under formal scrutiny by peers or by regulators.

Formal educational evaluations (including those concerning ethics) often have high stakes for participants, whether as part of a qualification, an appraisal for continuing professional development, or a medico-legal inquiry. The stakes keep ethics on the conscious agenda in the absence of dilemmas. Whilst evaluation keeps ethics education from vanishing, it simultaneously tends to circumscribe it to dominant themes and methods. Evaluation understandably therefore shapes learning, even to the undesirable point that only a preconceived set of issues are considered ethical, and only certain forms of analysis are considered legitimate for the purposes of assessment. The four principles of biomedical ethics, for example, are sometimes offered as if they are the only tool for ethical analysis that will satisfy either undergraduate or postgraduate examiners. This naturally follows from the widespread adoption of the four principles in the broad curriculum experienced by GPs. The disagreement by examiners over what issues can be presented as coursework relevant to ethics risks disadvantaging both philosophically less literate candidates who are unsure what to discuss when asked to present a case about ethics, and candidates offering more sophisticated presentations that do not relate to a pre-labelled topic, or that do not use the four principles to analyse an issue.

The ways in which knowledge, skills and attitudes relating to ethics are tested rely on a need for praiseworthiness (sometimes in the form of accreditation) in the candidate or practitioner. This may limit or distort how candidates respond under scrutiny, or whether they are prepared to venture beyond theoretical concepts and relate ethical ideas to practice.

Chapter 7: Ethics in practice

In this chapter I discuss how ethical issues are recognised and outline some strategies used by GPs to deal with ethics as it arises in practice. Issues are recognized in two ways: In the first instance they are recognized as a type of issue that comes pre-labelled as ethical, such as a request for abortion or assisted suicide or as a type of problem that has clear ethical connotations such as a conflict or dilemma, The other way of recognising ethical issues as they arise is emotional discomfort. I discuss how this may lead to ethical issues being raised in discussions about inter-personal difficulties in practice and how mentors, trainers and Balint-group facilitators (among others) may have a role in signposting ethics advice and support.

I also outline the strategies adopted by GPs in response to the issues they experience as ethical ones. I have grouped these to reflect the ways in which participants described their own and their colleagues' practices. Some GPs chose, in some respects, to avoid or ignore the ethical dimension of problems. Others deferred to rules or senior colleagues, either to validate their own opinion or to obtain an opinion more authoritative than their own. Some used developed rules of thumb or had internalised ethical ideas. I discuss the pros and cons of these strategies but note that explicit engagement with ethical issues can sometimes be a way of protecting the GP from emotional burnout, and reintroducing rationality, impartiality and fairness when decisions could not or should not be avoided or deferred.

Chapters 8 and 9: Substantive issues

In these two chapters, I will focus on four key ethical issues that participants discussed the most as being problematic for their daily practice. Confidentiality, abortion, financial incentives and rationing are all issues that have been discussed in academic and practice literature. In chapter 8, I will discuss how confidentiality and abortion illustrate GPs' need to negotiate ethical complexity in an area that is heavily legally and professionally regulated, as well as the possibilities for avoiding ethically and emotionally challenging professional encounters. I will discuss the limits of conscientious objection and distinguish it from ethical avoidance and I will discuss the problematic aspects of declaring religious belief as a conflict of interest when counselling a patient.

The theme of conscientious objection is revisited in chapter 9 and applied to beliefs about whether incentivising GPs' performance is ethical, and whether GPs should offer treatments which they believe are useless or harmful if patients have a notional entitlement to them.

I will use discussions about financial incentives and rationing to illustrate the tension between personalised holistic medicine as espoused by a traditional GP ethic and population-based medicine and the different ethical styles that may underlie them.

The purpose of the chapter is, in addition to highlighting the key substantive issues, to extract from these issues a better indication of the challenges, successes and failures of ethics education. A linking theme is the display of ethics - the need by GPs and general practice as a professional body to be seen as praiseworthy or right.

Chapter 10: Conclusions

In the conclusion I will reflect on the key insights from the preceding chapters. The data have been organised around the themes of curriculum, pedagogy and evaluation. As described above, these chapters have been informed by participant data covering the production, transmission and enactment of ethics as a kind of educational knowledge in general practice. This broadness of view covering the phenomenon of ethics education in the span of GP's career is one of my claims to originality in this thesis.

Societal forces and tensions are present when curricula are conceived, when knowledge and skills are taught and when GPs attempt to integrate learning into their daily practice. By attempting to understand these forces and tensions we can be in a better position to conceive how to move forward.

Ultimately this study aims to improve the reflexivity of ethics education. Many of the ethical shortcomings of doctors have historically been linked to hidden curricula; those features of practice and the practice environment that have been unseen or ignored by teachers or learners. Knowing more about hidden curricula provides some potential for being able to adjust for their influence. Accordingly this thesis seeks a social understanding of how ethics is produced, transmitted and enacted. It aims to offer insights that may generate further scholarly work and improve education in a way that allows GPs to better understand their ethical formation and professional boundaries.

Chapter 2: A theoretical approach to the study of ethics education in general practice

Introduction: Why discuss social theory at all?

The purpose of this chapter is to describe the theoretical underpinnings of the thesis, or the fundamental ideas which allowed me to ask initial questions and organise the answers into a story about ethics education in general practice. Research questions, it may be argued (Silverman, 2008) are inevitably theoretically-influenced. Theory provides a framework for critically understanding phenomena, as well as a basis for considering how what is unknown might be organized. Organizing ideas before going ‘into the field’ allows the researcher to focus the inquiry. Acknowledging relevant theory recognizes the notion that no one is a blank slate entirely free from preconceptions. Those same preconceptions may be debunked or even be illustrated and refined, rather than re-invented as if they had never previously existed.

From the outset, this thesis has sought to capture a sense of ethics translated between classroom and clinic. Unavoidably this must include a consideration of the interplay between structures and agency. The thesis takes, as its starting point, the idea that how ethical issues are framed and conceptualised for, learned by and engaged with in practice by general practitioners (GPs) will be influenced by factors internal and external to GPs. The importance of understanding ethics as enacted in (and modified by) the social world is the key justification for the contribution of the social sciences to the academic field of medical ethics. For example, Haimes suggests that research into an area of ethical distinctiveness that does not involve

social theory is missing something vital (Haimes, 2002) – she uses Shenck’s analogy of the rules of ball games (Shenck, 1986).

Shenck: Going into discussion of medical ethics attending only to ethical theories, without attention to phenomenon of embodiment, would be like going into a discussion of the rules governing ball games without paying attention to the differences between football, baseball and basketball, focussing only on abstract discussions on the nature of “rules” and “games” as such. Too often ethicists of medicine seem lost in just this way; and that is because they tend to ignore that which distinguishes medical ethics from business ethics or legal ethics which is of course the centrality of the body for the practice of medicine and the texture of embodiment of human life itself.

Ashcroft notes that the incorporation of empirical data into ethical argument often takes the form of a hypothetical imperative, where an argument of the form ‘if P then X’ is made, and then empirical data is used as evidence that P. However, he observes that most of the literature on empirical ethics and most contributions to this field concentrate on certain kinds of social inquiry. From a ‘Sociology of knowledge,’ perspective the question is not “Can this hypothetical imperative be completed by this body of factual statements?” but “What are the conditions of possibility for this statement?” Ashcroft illustrates the difficulties with this kind of inquiry by via the analogy of a language game (Ashcroft, 2003):

We are asking something like “If this is a valid move in some language game, what can we infer about the rules of the language game of which this is a valid move?”

The statement’s conditions of enunciation are under-determined by the information we have in front of us. Ashcroft offers some rules of reconstruction. He suggests that we can ask:

1. Who are the social subjects addressed by this discourse?
2. What sort of agency—if any—do they have?
3. Whose utterances are authoritative and when?

4. What are the dynamics of participation in the discourse?

Gewirtz and Cribb describe the relationship between structure and agency as one of the central theoretical challenges facing all of sociology. Whilst I do not propose to solve it here, this thesis does lean towards what Gewirtz and Cribb term a 'soft' or ontologically secondary appreciation of structure. This can be understood by examples such as financial currencies, which are clearly produced by humans and open to change, but nonetheless for most people (most of the time) provide limits for what it is possible for them to do. An even 'softer' example given by Gewirtz and Cribb that is in keeping with an analogy of games is the rules of playground chase, which constrain and give shape to the possibilities of play for the children participating and yet which might, in certain circumstances, be renegotiated and radically changed relatively easily and quickly (Gewirtz and Cribb, 2009b). A soft appreciation of structure allows the researcher to accept that some people can influence and others be influenced by social structures. In terms of his analogy (above), Shenck was explicit in clarifying his position that he was not opposed to abstract discussion of ethical characteristics or of meta-ethical theories. He argued, however that these were insufficient to found medical ethics (Shenck, 1986). This thesis takes the starting position that, at the very least, an understanding of the social world that is influenced by some and influences others is an important, if not completely essential, consideration in the study of ethics education. This is in keeping with the idea that a better appreciation of the social world in which ethics as an educational topic is studied, taught and enacted could lead to improvements in the study of, teaching of and practice of the same.

Ethics as educational knowledge or as regulation?

A theoretical awkwardness with the study of the ethics education of any professional group lies in nature of ethics as the indirect subject studied. According to Bernstein (Bernstein, 1971), educational knowledge is a major regulator of the structure of experience, an idea which informs my research. However, ethics is subject which can be perceived, intrinsically, to regulate behaviour –knowing that an action is right or wrong carries with it a potential obligation to act or refrain from acting in a particular way. For this very reason it is relatively easy to answer the question, ‘Who cares?’ when discussing whether there is reason to attempt understanding ethics education of general practitioners. General practitioners may care, even if for no other reason that the trust that their profession requires from patients is founded on a reputation for acting rightly. Governments may care, because in a healthcare system such as the UK’s NHS, they are accountable for the quality of healthcare provision. Patients may care, because trust in the GPs ability to act rightly may determine whether they choose to consult the GP, or to disclose their secrets during a consultation. The above examples are not intended to serve as a complete description of the ways that different stakeholders care about how GPs are educated about ethics, but they do serve to illustrate the idea that the subject of ethics can easily engage stakeholders.

Thus, a key difficulty with describing ethics as ‘knowledge’ lies in that ethics may be conceived as both a type of knowledge and a form of regulation. This means that by contrast with other types of knowledge, civil society and the state may stake a more overt claim to the shaping of professional ethics and consequently its education and assessment. To a degree this is evident in the legislation surrounding medical practice and the deliberate inclusion of ‘lay-people’ in medical regulatory bodies such as the General Medical Council (GMC). The GMC is the arbiter

of whether undergraduate and postgraduate education is fit for purpose. In their guide to undergraduate ethics curricula, Dowie and Martin highlight the phenomenon as a relevant one (Dowie and Martin, 2011b) . The direction of influence is also far from unidirectional -Salter captures a sense of this in the political triangle of ‘intersecting forces between the profession, civil society and state’ (Salter, 2004):

Dowie and Martin: All professions form a triangle of political partnerships in conjunction with the other two vertices represented by society and the state. However the exchange of benefits between these partners is contingent and can be endangered. In particular, according to Salter (2001), *‘Public trust in the medical profession is the key to the political arrangement between medicine, society and the state.’* Trust in the medical profession operates at two levels: in ethical practice as performed by individual doctors when treating their patients, and in the governance of doctors as performed by regulatory bodies (Dowie and Martin, 2011b, Salter, 2001).

The phenomenon that I have chosen to examine is the ethics education of general practitioners and therefore this thesis treats ethics as educational knowledge, albeit knowledge with particular properties for those involved in its production, transmission and embodiment in practice.

Messaging systems as applied to ethics education

According to Bernstein, formal educational knowledge can be considered to be realized through three message systems: curriculum, pedagogy and evaluation. Curriculum defines what counts as valid knowledge, pedagogy defines what counts as the valid transmission of knowledge and evaluation defines what counts as a valid realization of this knowledge on the part of the taught (Pollard, 2002). In the context of medical ethics education, I have equated curriculum, pedagogy and evaluation, broadly to academia, education and practice.

Perhaps artificially this thesis treats ethics as the knowledge skills and attitudes which are influenced by education rather than a form of regulation. A loose categorization based on curriculum, pedagogy and evaluation is helpful in organizing both the data and conclusions. A 'messaging system' approach has been applied within fields that intersect and border upon bioethics. For example, it is worth noting two broadly similar approaches to Bernstein's trinity of message systems, which have originated independently in the fields of anthropology and biopolitics.

In instances where ethics has been crystallised in the form of declaration, a regulation or policy, Hoeyer found inspiration in the field of anthropology of policy in terms of a framework to "study through" (Hoeyer, 2006a, Hoeyer, 2006b, Shore, 1997). Hoeyer suggests that where ethics as an activity becomes a form of knowledge or of governance it may usefully be looked at in terms of the interaction between policy-maker, policy worker and policy-target. In his case-study of a Swedish genomics company, Hoeyer uses this model to direct research questions towards an understanding of the development of the policy as it evolves at three levels:

(1) Policymakers: How the policy takes shape: Who names and frames the issues the policy will address? What becomes the object of regulation? This is broadly analogous to Bernstein's curriculum. Academics equate in my thesis to an influential set of policy makers. Academics (from an academic or professional vantage) name and frame the issues of concern, contribute to, and gather the professional curriculum.

(2) Policy workers: How the policy becomes entrenched in social practice. This corresponds to pedagogy – one of the ways that the policy becomes entrenched in any case will be through being taught by policy workers.

(3) Target group: What are the social implications of the policy for the target group? The target group for the purposes of my thesis are general practitioners. This is because I am studying ethics as an educational topic rather than ethics as a form of regulation.

Hoeyer's (Hoeyer, 2006a, Hoeyer, 2006b) methodological principle has been to move between these levels and mirror the different forms of framings of problems expressed at the three levels in each other.

Salter's framework (Salter, 2004) attempts to conceptualise the control of medical knowledge in terms of creation, transmission and practice. Salter attempts to simplify the idea using a grid (table 1).

Table 1. Knowledge control and the politics of regulation (Salter 2004: 8)			
Arena of Knowledge activity	Regulation Functions		
	Standard Setting	Monitoring & Evaluation	Intervention
Creation (Research)	1	2	3
Transmission (Education)	4	5	6
Application (Performance)	7	8	9

On the one axis, creation of knowledge is embodied in research, its transmission is embodied in education and its application is embodied in performance. On the other axis, Salter describes three kinds of regulation function: standard setting, monitoring and evaluation, and

intervention (Salter, 2004). The regulation functions are in effect social forces that act upon the messaging systems. Whilst less formal kinds of regulation function might be included, the legitimacy of their inclusion in Salter's framework is not obvious. The advantage of restricting the forces observed to formal regulatory processes is that they are (in theory) more easily defined and mapped.

At first glance the artificial subdivision of any practice – education or regulation- into a trinity of messaging systems does not recognise that participants do not necessarily just have one out of the three roles or a fixed role over time. For example, where academics also teach and practise clinical medicine there is scope to ask questions about how academics and educators apply their ethical expertise in clinical practice also.

Boundaries in academia, education and practice

Whilst Bernstein provides an appealing categorisation for the messaging systems of educational knowledge, each of those three categories contain individuals who both possess agency and are subject to external forces. Bernstein describes the underlying principles to his messaging systems in terms of boundaries, for example between different curricula and the educational subjects within them, or between the teacher and student in the pedagogical relationship (Bernstein, 1971). However his conception of boundaries seems limited to the educational setting and dwells in the main on curriculum and pedagogy. Gieryn's concept of 'Boundary-work' (Gieryn, 1983, Gieryn, 1999, Jasanoff, 2005) is a concept that I used as a concept that 'sensitised' me to some of the social forces influencing each of the three

messaging systems. Boundary work is a concept usually associated with the field of science and technology studies (ST&S)¹ rather than with the sociology of education. It is concept which has been successfully applied in the study of translational medicine (Wainwright et al., 2006), and I lean towards its use because I conceive of a study of ethics education as a form of translational ethics in itself as well as the study of ethics *translated* (Cribb, 2010). Sismondo summarizes the field of ST & S below (Sismondo, 2010b).

Sismondo: ST&S starts from an assumption that science and technology are thoroughly social activities. They are social in that scientists and engineers are always members of communities, trained into the practices those communities and necessarily working within them. These communities set standards for inquiry and evaluate knowledge claims... In addition science and technology are arenas in which rhetorical work is crucial, because scientists and engineers are always in the position of having to convince their peers and others of the value of their favourite ideas and plans –they are constantly engaged in struggles to gain resources and to promote their views. The actors in science and technology are also not mere logical operators, but instead have investments in skills, prestige, knowledge, and specific theories and practices.

Sismondo gives a very good summary of boundary work as well. His description illustrates Ashcroft's rules of reconstructing the conditions of 'allowable statements' above (Ashcroft, 2003).

Sismondo: When issues of epistemic authority, the authority to make respected claims, arise, people attempt to draw boundaries. To have authority on any contentious issue requires that at least some other people do not have it. The study of boundary work is a localised, historical, or anti-foundational approach to understanding authority. For example some people might argue that science gets its epistemic authority from its rationality, its connection to nature or its connection to technology or policy. We can see those connections, though, as products of boundary work. Science is rational because of successful efforts to define it in terms of

¹ Whilst STS might seem a more appropriate abbreviation for science and technology studies, the books I referred to used the abbreviation ST&S. I have consequently used ST&S rather than altering quotations.

rationality; science is connected to nature because it has acquired authority to determine what nature is; and scientists connect their work to the benefits of technology or the urgency of political action in particular situations when they are seeking authority that depends on those connections...

However as a theory pertaining to the sociology of knowledge, there is no reason why it should not be discussed outside the context of experimental or basic sciences. The notion of boundary-work has since been generalized and extended to the study of other 'boundary disputes' beyond the demarcation between science and non-science. According to Jasanoff (2005 at p.26), boundaries are everywhere at play in the world and the task of boundary-work involves the creation and maintenance of essential social demarcations. She suggests that boundary-work in contemporary societies is done by legal institutions as they classify new instances under a finite set of categories, in parliamentary bodies, courts of law, expert advisory commissions, ethics review boards, and a variety of other contexts (Jasanoff 2005, at p.27). Moreover, boundary work can be routine, occurring where there are no immediate conflicts imminent. Examples, people, methods and qualifications are all used in the practical work of charting boundaries. Textbooks and course, for example, can establish maps of fields simply through the topics or examples that they represent (Sismondo, 2010a).

Gieryn (1983) coined the term 'boundary work' by arguing that (in his historical case studies) scientists are subject to both 'strains' and 'interests' and demonstrate ideologies which accommodate both through the alteration of social demarcations. Gieryn associates strain theories with Parsons (1967) in arguing that ideologies provide evaluative integration in the face of conflicting demands, competing expectations and inevitable ambivalences of social life. Interest theories are associated with Marx. Marxist ideologies are social weapons, used by groups to further their political or economic interests in the struggle for power and advantage.

Gieryn follows Geertz (1973) in arguing that ideologies can both smooth inconsistencies and advance interests.

Gieryn uses three examples in his seminal paper (Gieryn, 1983): The first example comes from 19th century arguments defending natural scientists (scientists whom we might now recognise as studying physics). On the one hand physics was held to be equal or superior to religion in that it could provide useful provable truths about the world, which religion could not. On the other physicists were superior to engineers because they provided an underlying understanding about the world and theoretical discipline which engineers lacked. Moreover it was argued that engineers, being driven by profit and self-interest, were less likely to communicate discoveries of mutual benefit. Academic science is thus defined as practical and profitable in one circumstance, and yet in another setting it is described as theoretical and towards the universal good.

In his second example Gieryn described how 19th century Edinburgh anatomists called into question the scientific validity of phrenologists' work. The phrenologists were seen as competing for resources and prestige, by making grand claims about the utility of their knowledge. By describing those claims as untrue and unsubstantiated, the anatomists moved the boundaries of science so as to place the phrenologists outside science. The example emphasizes that such demarcations may have high stakes involved for the participants, and carries with it the implication that such boundaries are flexible and socially constructed.

Gieryn makes his third argument for combining 'strains' and 'interests' in describing US scientists' response to a proposal that their publications should be restricted during the cold war, lest a useful application be developed from those publications by enemies of the US. The rationale from scientists was incongruous. On the one hand military and industrial applications could be developed from scientific discoveries. On the other, it was unlikely that enemies of the US would develop the same from reading US scientists' publications. Moreover, to restrict

US scientists from communicating with their Russian counterparts would prevent them from learning about areas where the Russians were more advanced.

Criticisms of Gieryn's work by groups attempting to expand or test the concept of boundary work by empirical means fall into the following categories:

1. Gieryn's studies have focused on historical cases, rather than observing boundary work in the making (Albert et al., 2009).
2. Gieryn devoted most of his efforts to the demarcation between science and non-science, rather than among different types of scientists (Albert 2009), or different types of activity by scientists (Ehrich et al 2006, Wainwright et al 2006).

There is an immediate potential relevance of boundary work to the 'translational' messaging systems of education. I have suggested above that demarcation may be routinely accomplished in practical everyday settings (Gieryn, 1983, Gieryn, 1999, Jasanoff, 2005) which may just as easily apply to general practice academia as to physics: GPs might set up curricula that include philosophy but exclude theology as prescriptive of medical behaviour; Journal editors reject some manuscripts as 'not rigorous' or 'not evidence-based.' It is more than an academic issue to decide who teaches ethical decision-making (Sokol, 2008), what counts as relevant research, and even who should make or contribute to decisions which are classified as 'ethical' in the general practice setting (Savulescu, 2006).

These criticisms do not so much challenge the concept of boundary work as lend their authors the legitimacy to fill the gaps that they identify in Gieryn's work.

Those who have extended boundary-work have argued that it is equated with "ontological reordering". Wainwright et al describe an instance of this in the way that ethical boundary-work involves a process of social demarcation – where ethical talk is not only about

representing a contradictory set of ethical terrains but is also about ordering such terrains, by making social divisions which speakers identify with, or differentiate from (Wainwright et al., 2006).

In conclusion, I have chosen to use 'Boundary work' as the sensitising concept from which I begin to examine the structures which generally act upon and my less usually be influenced by the participants in this study.

Boundary work and curriculum

A key illustration of boundary work in academia is the argument, made by academics, that their own academic disciplines or fields have lives that need saving (Toulmin, 1982, Hoffmaster, 1992) – in other words, authority, resources and prestige can be both necessary for a discipline to flourish, and a sign that an academic discipline is flourishing. Relevance in the real world outside the classroom is one way in which academic fields and disciplines are justified, and this bears direct relevance to my thesis, because academia provides content for the curriculum and may influence who can legitimately teach that content. If academic disciplines are embodied in their advocates and disciples, 'strains and interests' (Gieryn 1983) can be a useful way of looking at this. For example there is an often quoted idea that a medical context has 'saved' the life of ethics and has given back a seriousness and human relevance to the subject of ethics (Toulmin, 1982). By contrast with the idea that ethics might be seen as a somewhat dry and unexciting subject that might not attract large amounts of funding or public attention, Toulmin describes the increasing prestige of bioethics in America.

Toulmin: Before long moral philosophers (or as they barbarously began to be called, 'ethicists') found that they were as liable as the economists to be called on to write 'op ed' pieces for the New York Times, or to testify before congressional committees...(Toulmin, 1982)

According to Toulmin, the new medical ethics saved the life of ethics as an overlooked and under-resourced discipline by applying ethics outside the classroom. Toulmin argues that ethicists applied rationality to and therefore resolved arguments over matters of public policy i.e. they made themselves useful, and placed themselves in public view. They achieved this by colonising an area of interest, medical ethics.

Barry Hoffmaster subsequently (Hoffmaster, 1992) wrote the again much quoted, “Can ethnography save the life of medical ethics?” In his paper he argues firstly that medical ethicists are not making enough explicit connection between theoretical foundations and practical application and secondly that clinicians are not engaged enough with medical ethics – to the point where they find academic medical ethics an irrelevance. On this occasion ethnography and other empirical methods are admitted into medical ethics, ostensibly as a way of maintaining the field’s ability to achieve relevance.

Conclusion: Situating the thesis

In this chapter I have suggested that in the particular context of medical education, ethics, if it is to be considered part of the medical curriculum, can be considered in a similar way to other kinds of knowledge that are categorised and shaped by academics. The study of ethics education in medicine is translational in a manner broadly analogous to translational medicine. Cribb suggests there is some merit in the idea that that much as translational research attempts to connect the laboratory scientist’s work to its implications for patient care, translational ethics focusses on bringing ethics scholarship into the sphere of personal and public action (Cribb, 2010). Like Cribb, I distinguish the term ‘translational ethics’ (the study of ethics being translated) from the two other key definitions in the bioethics literature.

Translational ethics has been defined as a new way of doing medical ethics based on principles

derived from the ethics of human research. It has also been defined as the ethical issues implicit in translational medicine (such as the ethics of making claims about the potential applicability of a new biomedical discovery). These latter two understanding of translational ethics are not alluded to when I use the terms translational or translational ethics.

Bernstein's messaging systems are (I use the term loosely) translational, in that they are used to study how a type of knowledge or regulation is created, transmitted, and applied. This study seeks to be a kind of translational ethics. I propose that a similar, translational approach to the study of ethics education in General Practice can be both academically relevant and practically useful. There are evident multi-directional relationships between research (or curriculum), education (or pedagogy), and performance (or evaluation). The interrelation of agency and structures rather than emphasis on one or the other is implicit in a work that attempts to analyse the experience of ethics education in order to in some way improve it. Whilst what counts as relevant knowledge, how it is taught and how it is enacted might be shaped by the strains and interests implicit in boundary work, my initial position is that some individuals may be in a position to influence such processes.

Understanding these relationships better might lead to improvements in what is taught, how it is taught, and the application of what is taught. The major reflexive point to be made here is that by making such a claim, I am engaging in a kind of boundary work.

Chapter 3: Methods

Introduction

The Oxford dictionary of sociology defines either the general approach or research techniques as 'methodology' (Marshall, 1998) Here both the general approach to the research and the techniques themselves are set against the research questions and aims of the study. The chapter thus describes the methodology for my qualitative study into the ethics education of UK general practitioners. This research looks at how UK GPs (and selected stakeholders who participate in the shaping of general practice ethics education) identify, categorise and attempt to reconcile ethical problems which arise in the context of general practice.

In this chapter I discuss how my research questions and key theoretical ideas have influenced my methodological choices. This thesis sets out to examine ethics education as the active translation of knowledge between theory and practice. In the previous chapter I accordingly discussed concepts from the sociology of education and the sociology of scientific knowledge. These were the concepts that would allow me to be receptive to and to organize the ideas emerging from the data. By contrast, the theories and techniques that I discuss below relate to how I engaged with the field of study in order to obtain the data.

As well as describing my chosen methods, I discuss practical and theoretical reasons why I have chosen interviews and one focus group for data collection. I go on to discuss my place in

the field and the approach to taken to sampling. Sampling for this study has been connected with analysis of the data. Though this study does not claim to be a grounded theory of general practice ethics, I have chosen to use modified grounded theory coding as a key influence on the thematic data analysis. Some participants were selected on the basis of gaps emerging in my data as I conducted interviews, and all participants were selected on the basis of their connection to the phenomenon of ethics education in and for general practice.

The final part of the chapter is a discussion of ethical and research governance considerations. My position as both as a GP and as a perceived ethicist created a set of obligations that may have deterred some from participating. I reflect on whether this has a broader resonance within GP ethics education.

Choosing a qualitative empirical methodology

An empirical study of ethics-related phenomena in general practice arguably may be considered to be included in the body of literature that has been called empirical ethics. The study of empirical ethics encompasses the idea that the study of people's actual moral beliefs, intuitions, behaviour and reasoning yields information that is meaningful for ethics (Borry et al., 2004). It may involve description and analysis of the actual conduct of a group with respect to a morally relevant issue (De Vries and Gordijn, 2009); for example: describing compliance with existing moral norms and determining whether policies or procedures designed to operationalize certain moral norms have been successful. Normative theories may depend upon assumptions that can be empirically tested (Sulmasy and Sugarman, 2001). Empirical

study may identify moral issues that have escaped the attention of ethicists, but which are relevant in specific contexts. It is important to describe and analyse the actual moral opinions and reasoning patterns of those involved in a certain practice.

Its proponents claim that empirical ethics is important because ethics is enacted in the real world. To be able to guide action in a sphere of practice, ethical recommendations must be sufficiently accepted by the people involved in that practice. If it is to stand a good chance of adoption, it should therefore be formulated in a way that stresses continuity with those people's already accepted moral beliefs. Some may view moral beliefs in practice as a source of morality per se. The making of ethical policy that is more context sensitive or realistic may follow on from this idea (Birnbacher, 1999). Thus talking to GPs will allow a more grounded and detailed analysis of perspectives, processes and practices that are often erased or 'skated over' by purely philosophical analyses. A qualitative approach has been used to good effect in mapping ethical approaches to human embryonic stem cell research (Wainwright et al., 2006) and pre-implantation genetic diagnosis (Williams et al., 2007).

This study examines 'general practice ethics' as a field by examining the literature and by talking to three types of actor: academics, educators, and practitioners in relation to the same, whilst taking into account the influence of, and the influences on the researcher.

This study seeks to map how ethics scholarship relates to moral decision-making in general practice. The notion that what is ethics and what is ethical is variously interpreted and far from universally agreed mitigates against use of a quantitative tool e.g. a survey. Qualitative research is often defined by reference to quantitative research (Pope and Mays, 2006a). This

study is concerned with meanings and participants' interpretation of situations and decisions. A qualitative method is thus a positive choice.

There has been a noted increase in the use of qualitative research methods in medicine and health care during the last decade (Walker Holloway and Wheeler 2005: 90). For many social scientists, the choice of a particular research method is linked to a particular theoretical perspective, or set of explanatory concepts, that provide a framework for thinking about the social world and inform their research. However, Some have suggested that the link between theory and methods is overstated and that the choice of method and how it is used as likely to be informed by the research question or pragmatic or technical considerations as by the researcher's theoretical stance (Pope and Mays, 2006a).

Influences of Phenomenology and Ethnography on this Study

In conducting this study I sought to capture the lived experience of ethics education as Phenomenology has its roots in philosophy. As applied to qualitative research, it seeks the essence of lived experience. The goal of a phenomenological approach would be to produce a narrative that allows readers to share in the experience of the research participants. Consequently it would rely on methods such as in-depth interviews (Chandros-Hull et al., 2001). This study relies on foreknowledge of the field as well as seeking to capture and distil the experience, knowledge, attitudes and beliefs of participants. A foreknowledge of both ethics and general practice was unavoidable for me as I had trained as a GP, and had also obtained qualifications in medical law and ethics.

Ethnography is an approach with anthropological origins. Ethnographers aim to describe a culture by immersing themselves in it. This often involves at least several methods of data collection including interviews and document collection. Ethnographic approaches often incorporate a formal element of observation.

There is a school of thought which views ethnography with participant observation as a superior way of seeing what participants actually do rather than (or in addition to) what they say they would, or justify what they did. Participant observation has been extolled as way to observe ethics in action (Hoffmaster, 1992, Parker, 2007). In seeking to find out how GPs 'do ethics' it would appear logical to do participant observation of GPs followed by interviews about the morally problematic cases. Slowther makes this case in her PhD Thesis (at p. 286):

A limitation of most published empirical ethics studies in the clinical context of primary and secondary care is their reliance on the participants' identification of ethical issues, or the researcher's prior determination of the ethical issue or issues to be studied thus studies that combine observation of the clinician/patient consultation, together with interviews with clinicians and patients following the consultation, would provide useful data on ethical issues that were not identified by the researcher (Slowther, 2004).

There are good intentions behind such a statement: the inclusion of patient as stakeholder, the avoidance of researcher-bias and the generation of scientific data which is triangulated in a way that is meaningful are worthy aspirations. However, the limitations cited do not detract value from the aim of this thesis. I want to know what GPs perceive as ethics and ethical issues

and to understand how this relates to their education. Therefore asking patients would only serve to highlight areas of similarity and difference and whilst worthwhile per se it would be answering a different question. There is a vast social science literature which seeks to capture patient experience, and relatively little that seeks to capture that of the clinician. My research aim was to understand how GPs encounter ethics in their education. Therefore the only participant in this study who was not a GP was included because she commissioned postgraduate academic education for GPs in ethics.

This study also does not involve formal participant observation in combination with the interviews and focus groups. I chose not to conduct formal observation methods on theoretical and practical grounds. Whilst there is a position that the theoretically ideal approach should be taken 'whatever it takes' the reality is that there are many barriers to conducting certain types of research, both internal (funding and resources) and external (research governance) to the researcher. My reasoning is as follows:

1. Not all ethical problems arise in the consultation, or even in the physical surgery environment (Hoffmaster et al., 1982). The research strategy would also, considering the often unpredictable, unselected nature of the consultation, be extremely time-consuming with no guarantee of any relevant data. Similarly this study is examining the reasoning of GPs for issues which they classify as ethical.

2. Observation, if it picks up anything, is more likely to pick up situations and procedures either which the observer classifies as ethical or which are awkward for a myriad of reasons for the

GP. Consequently the most ethically interesting consultations might be those which doctors and patients might prefer to keep unobserved. Researching sensitive topics, such as the rationing of treatments and denial of care, or the study of potential inconsistencies between general moral values and specific professional practice, raises a number of ethical and methodological problems. Direct observation may “damage the consultation” and therefore be unethical per se (Berney et al., 2005). Jefferys and Sachs observe that the “Main activity of general practice –whatever its setting- is not readily observable. The consultation between doctor and patient is a private privileged occasion...” and that the chief exception to this is medical education and training (Jefferys and Sachs, 1983). Patients in general do not expect to see two ‘doctors’ in a GP consultation and the constant need to check that patients consent would serve as a constant reminder of the presence of an outsider. Consent from every patient is an issue which I perceive from my training in general practice, which involved video-taping consultations as an educational tool. The idea that patients deserve to be proactively reassured they will not be observed while disrobing or that specific exams or procedures will not be observed without explicit permission has been discussed in the context of American family practice education (Butler, 2002, Quillen, 2002). Furthermore, some patients may not feel empowered to refuse participation. Wilson, Draper and Ives suggest that, “This may be a particular problem when patients have their own family doctor, whom they generally see, and the patient feels dependent on their practitioner’s good will for ongoing care” (Wilson et al., 2008). This introduces further practical difficulties but also reinforces the presence of the observer and can change the nature of the consultation unless some kind of ‘en-bloc’ consent can be obtained.

3. Observation carries duties to intervene if an observer sees unsafe or professionally unacceptable practice, more so if one has extra professional duties as a clinician (Goodwin,

2006). Observers may be tempted to participate, especially if they have ethical or clinical training (Bosk, 2008). I consider that the notion that a fellow doctor in the same speciality is less threatening and less likely to change the consultation is idealistic. On the one hand a GP might be more threatened, perceiving that someone with expert knowledge might be judging them, especially if on the lookout for ethical problems. The converse situation is that if one is perceived as having a) knowledge of general practice and b) knowledge of ethics then one might be invited to participate in consultation or other interaction of interest. Whilst ethically correct in the individual circumstance, this kind of intervention has some possible consequences: It may raise issues of informed consent and give participants a false sense of security or conversely may deter participation. Interference may also affect the data collected in ways which alter and may be perceived to compromise validity.

4. Ethical approval for participant observation in NHS practices across the country could necessitate multiple applications to NHS Research and development offices, possibly 'honorary contracts' in more than one primary care trust and a criminal records bureau (CRB) check. Though I was CRB-checked by virtue of my clinical work, the process of sending or (less liable to loss of crucial paperwork) taking the relevant piece of paper to multiple human resources departments can create significant delay and a PhD is a time-limited degree. These all take time away from the limited time-span for a PhD. Though it is likely that there was theoretical justification for the choice of research location, others have tended to conduct their qualitative studies of rationing in primary care in one region, close to the academic centre linked to their research (Berney et al., 2005, Hussain and White, 2009). My participants are spread over a geographical area which included urban London and rural Scotland. I also note that neither study appears to seek patients' views or conduct observation of the GP consultation –Berney et al certain attempt to justify this in theoretical terms (see above). Obtaining individual

consent from patients is a difficult undertaking in general practice when patients move rapidly in and out of the clinic (McKeganey, 1989). The difficulty with obtaining informed consent from all those observed, given the brevity of most interactions in the day to day general practice environment, is unlikely to secure Research Ethics Committee approval.

Taking into account the constraints of research governance and the requirements for ethical approval, interviews and focus groups provide a balance of safety for the respondent against the generation of useful data for the researcher. General practitioners understand and are at ease with the interview as a method for collecting information. Although the semi-structured interview is unlike much of their own interviewing, the basic process of having a guided conversation with another individual is one with which they can identify (Borkan, 1993). I would go further and add that focus groups have for a long time been a staple of General Practice education in the UK and indeed that discussion is a preferred method for teaching and learning medical ethics in this context (Gillies, 2009). In combining interviews with a focus group method Berney et al were able to examine points of fracture and agreement among GPs concerning different ethical principles before examining different ethical practices and their correspondence with the principles (Berney et al., 2005). They found that there were gaps between what prevalent ethical theories might suggest as an appropriate course of action and how GPs actually reasoned. They called this a 'Theory-practice gap'. Where a sense of 'theory-practice gap' emerged, they were able to question the reasons for this, the GP perceptions of it and the justifications given for the gap. They found that the multistage nature of research meant that they were able to develop greater levels of trust with the GPs than they might have done with a simple one-off interview.

The methodological approach to the gathering and analysis of data in this study does not completely adhere to the full requirements of either of the above traditions. However, elements of both of the above are present. I have endeavoured to learn all I can about the phenomenon of general practice ethics and use in-depth semi-structured interviews in the hope that the ensuing narratives will capture the essence of the phenomenon. I also immerse myself (see Reflexivity, below) as a participant in the relevant culture, and use multiple methods. Ethnographers are described as generally using multiple data sources and data collection techniques to obtain rich and overlapping data (Marshall and Koenig, 2001, Gordon and Levin, 2008). This is not enough, however, as the aim of the collection of data about the process of general practice ethics is to discover and develop a theory which accounts for and possibly improves this process.

The Method

Sampling and recruitment of participants

Whilst planning this study I repeatedly encountered the expectation from my non-medical peers that access to research participants would be straightforward. Britten writes:

Sociologists conducting research in medical settings often have to negotiate access with great care, although this unlikely to be a problem for clinicians conducting research in their place of work. (Britten, 2006)

Whilst access has been facilitated by my participation in the field, justifying my sampling strategy on the basis of more than convenience has been harder. Moreover there has been a need to steer between perceptions of inadequacy with a convenience sample, of researcher-bias with a purposive sample, and incompatibility between convenience and theoretical sampling.²

I made personal contact with key players in a field who supply different pieces of a theoretical picture. This thesis examines a phenomenon in the context of a particular speciality within medicine rather than the inside of one geographical location. There are elements of elite-interviewing and insider research at play in this study. One may be 'purposive' about convenience and snow ball sampling (Smith-Doerr, 2009, Conti and O'Neill, 2007). Political scientists, for example, are accustomed to interviewing 'political elites' who are chosen because of a particularly influential role in the policy process (Delaney, 2007). Several authors

² This was cited as a reason for not funding the research by the Royal College of General Practice Scientific Foundation Board, personal correspondence dated November 2009.

who have employed the term 'elite' have attempted to re-define it to suit the specific purposes of their research (McDowell, 1998, Parry, 1998, Smith, 2006). Delaney describes 'organizational elites,' meaning "...that the elite status of my interview subject is a direct consequence of holding a particular position in an organization, as opposed to, say, having a high net worth or having specific influence of one sort or another" (Delaney, 2007).

These attempts at re-defining what 'elite' signifies suggests some researchers already acknowledge the subjectivity involved in identifying who is and who is not 'elite' (Smith, 2006). Even the most junior of the 'purposed' participants in this study share some or many features with Delaney's organisational elites, "Some are private and might not want to be interviewed and most, of course, are extremely busy. On the other hand, organizational elites are often intellectually interested in the projects we work on, they readily understand the idea of doing 'academic research', they have reliable calendars and schedules (and even people who keep them), and they have places to meet (their offices)." (Delaney 2007: 212)

Studies on elite interviewing advise researchers to draw attention to their institutional affiliation, use personal connections where possible, and seek to obtain an influential "sponsor" whose endorsement of the project will ensure the cooperation of the rest of the group (Ostrander, 1993). In one sense I am my own gatekeeper, as an active participant in the field (see reflexivity) which I have chosen to study. In that my sample is non-random and there is an element of purpose in deciding who is invited to be interviewed or a focus group this sampling strategy is purposive. Participants must have the qualities of a good informant, i.e. be willing to participate in the study, have time to be interviewed, be knowledgeable about the research topic and be articulate (Morse, 1986). In many qualitative studies not all informants

are able to articulate their experiences. Where I asked one participant to refer another, I asked to be referred to a purposed kind of participant. Purposiveness is expressed by Conti and O'Neill in their study of the dispute settlement mechanism of the World Trade Organization (Conti and O'Neill, 2007), "Drawing on three contacts obtained through personal networks, I found the rest of the sample through *purposive*³ 'snowball' sampling and by directly contacting trade ministries."

The potential suitability of informants in this study was initially based on personal knowledge of 'key players' in the field. Theoretical sampling is also used. Theoretical sampling is used here to mean something subtly different from purposive sampling. As the aim of the research is to provide accurate and rich descriptions the sample is selected according to the informant's knowledge of the research topic. Theoretical sampling learns from the ongoing analysis (Covan, 2007, Morse, 2007). The methodological approach selected for this study contains a systematic exchange between data collection and analysis to generate and validate theory. Therefore, the theoretical results of the first circle of analysis are scrutinised on the basis of the next interviews and new categories will be developed to close the remaining theoretical gaps. The enrolment of participants is finished when new data do not enrich or refine the categories any more (theoretical saturation).

This thesis does not seek statistical representativeness. To invite responses by, for example, a mailshot to every tenth GP in the College Directory seems a bureaucratically intensive and expensive way to ensure self-selection, whilst at the same time ignoring vital perspectives. One previous researcher using this method in among South Australian GPs found that two out of 18

³ my emphasis

respondents came forward simply because they had known her at medical school (Braunack-Mayer, 2005). Thus, in grounded theory the concern is with representativeness of concepts and this is achieved through theoretical sampling. However, the level of theoretical sampling reached is dependent on the level of analysis reached. In axial coding "data are put back together in new ways after open coding, by making connections between categories" (Strauss and Corbin, 1990, Strauss and Corbin, 1998).

As I (see section on reflexivity) have a large number of personal contacts in academia, general practice education, and 'ordinary practice' it is possible to purposively select from an initial convenience sample it is then possible to invite existing participants to 'refer' colleagues who address emerging theoretical gaps (or indeed to select such individuals from the original 'pool' of potential participants). A similar approach has been used by Schildmann to recruit German palliative medicine physicians for a qualitative study (Schildmann and Vollmann, 2009). In her interview study of life-scientists' reactions to ethical training requirements, Smith-Doerr also began a convenience/snowball approach to life-scientists. She used, "A diverse set of leads from my own networks (for example, from faculty at different institutions, graduate students from different disciplines, and friends and family members—in other words, people unconnected to each other in my own professional network), and also tried cold calls, based on public information about scientists on websites. The cold calls led to interviews rarely in the U.S. and U.K., and never in Italy" (Smith-Doerr, 2009). Smith-Doerr also asked participants to refer colleagues in the other countries she was interested in. In her exploration of the interaction of gender with the management of chronic illness during adolescence, Williams used networks established in her role as a Health Visitor to gain access to participants via seven GP surgeries in the same area (Williams, 1999, Williams, 2000). Provided that ethical

concerns are addressed (see section on ethical considerations below) personal networks can be a legitimate route of access to the field.

Smith-Doerr was interested in typical life-scientists and so did not select for special knowledge of ethics (Smith-Doerr, 2009). Braunack-Mayer was interested in the 'mythical average' how Australian GP inter-related bioethics scholarship and moral deliberation (Braunack-Mayer, 2001, Braunack-Mayer, 2005). This project needed a slightly different approach, one which required a kind of theoretical sampling. In seeking to capture a sense of how bioethics scholarship inter-relates with moral deliberation by UK GPs I was interested in academic and educational experts in the field. Access might be improved by a respondent's interest in the subject, or one aspect of it. It would be naïve to think that people who theorize and research and who teach ethics to GPs are themselves value-free, especially those who espouse particular ethical frameworks. To exclude participants involved in academia on the basis that they are articulate and outspoken seems counter-intuitive if it is their writings and teaching which are (in theory at least) influencing practice. One may even discover how such individuals transmit their ideas, and whether such individuals embody theory in practice. Conversely it may be useful to seek out opinions which one might expect to have become main-stream but which in fact have not.

Consequently the recruitment of participants began with a small number of GPs and academics who are involved in 'Primary care ethics' teaching and research, and then followed both the principles of "snowball sampling" as well as "theoretical sampling." A small number of GP educators and academics were initially invited to participate. These participants then identified further GP trainers and GP trainees and contacted the researcher only if these colleagues were

interested in and willing to participate in the study. Participants who are interested in participating were approached by email or (if they preferred) by telephone in order to explain the purpose of the study and provide the information sheet and consent form at least 1 week in advance of the interview or discussion group.

To reflect the anecdotal and empirical differences in issues raised by rural and inner-city GPs, interviews were held in both urban and rural settings. The relevance of different settings is a recurring theme in empirical research in General Practice ethics (Hoffmaster et al., 1991, Braunack-Mayer, 2005)

The final number of the participants depends on the "theoretical saturation" of the concept generated with the help of the empirical data. Guest et al (2006) suggest that saturation can be achieved after as few as 12 interviews with a participant group. A difficulty with using theoretical sampling lies in the uncertainty about final numbers. There are relatively rigid requirements from Research Ethics Committees and funding bodies to estimate numbers of participants and focus groups in advance. Another difficulty may lie in communicating the validity of the smaller numbers needed to achieve theoretical saturation than statistical significance, an altogether different concept which is a cornerstone of the evidence based medicine movement.

The estimated number for this study was 20 GPs, 10 academic or regulatory stakeholders for interview and two or four focus groups to account for the diversity of experience and social background amongst UK GPs. I was prepared for the possibility that the numbers may increase

or decrease depending on theoretical saturation being reached. I conducted 19 interviews and one focus group. The lower numbers reflected the huge volume of data and the repetition of themes in discussion signaling the presence of saturation.

The use of multiple complimentary methods: literature review, interviews and focus groups in this case has been regarded as a form of triangulation and to lend validity to the ensuing data (Chandros-Hull et al., 2001).

Interviews and focus groups

I conducted nineteen semi-structured interviews and one focus group of five participants.⁴ All participants were selected for their connection to ethics education, either as academics, educators or practitioners with a variety of experience. All but one participant were GPs at various stages of their careers from training to retired. The non-GP was an organizer of ethics education for GPs, working in an academic department of primary care, and thus contributed to the whole picture of the phenomenon being studied. The focus group was composed of GP-trainees as this group was the most difficult to access for semi structured interviews.

The consensus on semi-structured interviews, and the reason why I used them, is that they provide the opportunity to gain an account of the values and experiences of the respondent in terms meaningful to them (Stephens, 2007). The interviews included GPs from both urban and rural settings, this having previously identified as relevant to the way in which GPs make moral decisions (Braunack-Mayer, 2001).

⁴ I have included the topic guides I used as Appendices F and G

The focus group of GP trainees took place as an adjunct to a half-day education session outside the clinical environment. It is believed that homogeneity in a group is less intimidating for participants. Moreover a group moderator (facilitator) which the group identifies with and is not intimidated by (through seniority for example) may work well (Chandros-Hull et al., 2001). I acted as the group moderator. The focus group was conducted under Chatham House Rule for the participants. Chatham house rule is an often misunderstood concept, for example, "Discussions took place under 'Chatham House Rules' of confidentiality; this report therefore refers generally and without specific reference to individual commentators" (Medlin and Harper, 2003). The Chatham House Rule originated at Chatham House in 1927 with the aim of providing anonymity rather than confidentiality to speakers and to encourage openness and the sharing of information. It is used as an aid to free discussion. The Rule is not considered the same as 'off the record'. It allows people to speak as individuals, and to express views that may not be those of their organizations, and therefore it encourages free discussion. This is so participants do not have to worry about their reputation or the implications if they are publicly quoted.⁵

⁵ More details of the Chatham House Rule may be obtained from the Chatham House Website <http://www.chathamhouse.org.uk/about/chathamhouserule/> accessed at 1800 on 17/01/10

Dramatis Personae (Participants)

The table below summarises the key characteristics of the participants. I have deliberately not included certain demographic information that might be used to identify them. I do, however, use a number of descriptive terms about the participants. I have called anyone who contributes to the body of knowledge called ethics or with involvement in research that relates to this field an academic. I have referred to anyone with a formal educational role (such as teaching students, supervising trainees or commissioning ethics education) as an educator. I use the term leader to denote a formal leadership role within a medical institution (e.g. within professional bodies, academic institutions or clinical commissioning consortia). In the table I have noted the gender of each participant. More men than women participated (14:11) in the study, and whilst I cannot make any statistically significant inferences, this particular demographic may change if this study is repeated in subsequent years. I have also included a general description of the participants' location of practice but not named that location. Connected to location are questions about whether physical proximity to professional and academic institutions and degrees of geographical isolation might affect ethics education and support. Moreover, the possibility that issues might be experienced differently in different geographical settings (e.g. urban vs. rural) was one which I set out to accommodate from the outset of this study.

Pseudonym (in alphabetical order according to randomly assigned letter)	Roles in academia, education, policy and practice	Gender	Location of practice
Prof A	Full-time academic/educator, IMG	Female	N/A (former GP overseas)
Dr B	GP Partner, academic/educator/leader, UK graduate	Male	Urban
Dr C	GP Partner /educator/philosopher, UK graduate	Male	Rural

Dr D	GP Partner in First five years since qualification, IMG	Female	Urban
Dr E	GP partner, academic/ethicist/educator, UK graduate	Male	Suburban
Dr F	GP trainee in final year of training, leader (medical politics), UK graduate	Female	Suburban
Dr G	Retired GP Partner /educator/leader, UK graduate	Male	Semi-Rural
Dr L	Non GP Clinician with PhD/ Full-time academic/educator, UK graduate	Female	N/A
Dr M	Sessional/Locum GP educator/ethicist, UK graduate	Female	Urban
Dr N	Locum GP, No academic, education or leadership roles, IMG	Female	Urban/Suburban
Dr O	Salaried GP/Leader, UK graduate	Male	Rural
Prof P	Salaried GP/leader/academic, UK graduate	Male	Urban
Dr Q	Salaried GP, UK graduate	Male	Urban
Dr R	Salaried GP, academic/philosopher/educator, UK graduate	Male	Suburban
Dr S	GP partner/educator/ethicist/leader UK graduate	Male	Urban
Dr U	Sessional/locum GP and Retired Educator/Leader. UK graduate	Male	Urban and Rural
Dr W	Locum GP/Leader/GP commissioner, UK Graduate	Male	Urban
Prof Y	GP Partner /academic/ethicist, UK Graduate	Female	Urban
Prof Z	Retired GP Partner /Academic/Ethicist, UK Graduate	Male	Urban
Focus Group: Drs H.I.J.K. X.	GP trainees (none with any teaching or academic role), All UK graduates	1 Male, 4 Female	Urban

Other sources of data

In the section below on reflexivity I allude to the idea that I have very deliberately taken an expansive view of 'data'. Given that I am immersed in the academic and practical contexts I was studying, I sought not to be too rigidly circumscribed by the notion that I was 'data collecting' only some of the time. My own voice as a GP who teaches ethics does appear in some of the chapters, as do some of the resources that I, as well as the participants, encountered with respect to ethics education. This expansive view of data also enables me, on occasion, to sketch in richer accounts of context than would be possible purely by relying on my fieldwork data understood in the narrow sense – this is the case, for example, in chapters 5 and 6 on education and evaluation.

Analysis: Coding derived from Modified Grounded Theory

The interviews and focus group were recorded, transcribed, combined with field-notes and subjected to thematic analysis. The interviews and focus groups were transcribed and analysed using a approach influenced by grounded theory, and thematically coded using NUD*IST⁶ (NVivo8) software.

The method selected for the analysis of data in this study is derived from Grounded Theory as modified by Strauss and Corbin. Grounded theory contains a systematic exchange between data collection and analysis to generate and validate theory. The theoretical results of the first circle of analysis are scrutinized on the basis of the next interviews and new categories will be developed to close the remaining theoretical gaps. The enrolment of participants should conclude when new data do not enrich or refine the categories anymore (theoretical saturation). Interview and discussion group transcripts were analysed following the main principles of Grounded Theory. Sections of the first transcripts were selected and conceptualised. The concepts are compared and merged into categories if similar (open coding) (Strauss and Corbin, 1990).

In the next step of the analysis these categories were improved and links between them will be established (axial coding). Due to this procedure, insights into complex and emotional issues can be extracted from samples that are much smaller than those required for quantitative

⁶ “Non-numerical unstructured data indexing summarizing and theorizing,” is taken here as a generic term for this type of software. NVivo8 was chosen for its widespread availability and simple interface.

research methods. The results are not statistically representative for GPs in the UK but still provide insight into the process of UK general practice ethics.

Theoretical sensitivity in analysis of the data derives from a grounded theory tradition (Chandros-Hull et al., 2001). Orthodox followers of grounded theory might disagree that this use of theoretical sensitivity is appropriate or should even be called grounded theory. I do not claim that this study used a grounded theory approach, only that it is influenced by it.

Reliability and Validity

Mays and Pope use the term 'reliability' and claim that it is a significant criterion for assessing the value of a piece of qualitative research: 'the analysis of qualitative data can be enhanced by organizing an independent assessment of transcripts by additional skilled qualitative researchers and comparing agreement between the raters' (Mays and Pope, 1995). A contrary position is taken by Morse who argues that the use of 'external raters' is more suited to quantitative research; expecting another researcher to have the same 'insights' from a limited data base is unrealistic: 'No-one takes a second reader to the library to check that indeed he or she is interpreting the original sources correctly, so why does anyone need a reliability checker for his or her data?' (Morse, 1994). Armstrong et al have wryly pointed out that the example used by Mays and Pope (1995) for inter-rater reliability was actually one of ascribing quantitative weights to pre-given 'variables' which were then subjected to statistical analysis (Armstrong et al., 1997). They tested the degree of inter-rater reliability that might be expected by asking six researchers to identify themes in the same focus group transcript. The results showed close agreement on the basic themes but each analyst 'packaged' the themes differently. They conclude that "Analysis is a form of interpretation and interpretation involves

a dialogue between researcher and data in which the researcher's own views have important effects." (1997: 601) Pope, Ziebland and Mays respond that "Armstrong et al. conducted a tough test of inter rater agreement and one which would be unusual in a typical research study" (Pope et al., 2006).

Nevertheless, Pope et al maintain that that there may be merit in involving more than one analyst in situations where researcher bias is perceived to be a risk by others, citing examples of social scientists investigating the work of clinicians or evaluating government policy. In this study I discussed emerging themes and anonymised dialogue extracts with my supervisors. This did not represent a formal attempt at inter-rater reliability but ensured that I not only remained open the possibility of more than one possible interpretation but also that I did not ignore interesting data simply out of over-familiarity.

Validity has been defined as the extent to which the account accurately represents the social phenomena to which it refers (Pope and Mays, 2006b). LeCompte and Goetz write about internal and external validity. Internal validity is how well researchers' observations match the theoretical ideas which develop. This is a strength of qualitative research, especially where, participation in the social life of a group over a long period of time enables a high degree of congruence between concepts and observations. For the purposes of this study I argue that I participate in the social life of the spectrum of possible participants. External validity refers to how far findings may be generalised across social settings. This may be seen as problematic on account of the small sample sizes and case studies used in qualitative research (LeCompte and Goetz, 1982).

Guba and Lincoln use the terms dependability, credibility, transferability and confirmability to describe the trustworthiness of qualitative research (Guba and Lincoln, 1994). Dependability relates to the idea that the reader may audit the decision trail of the researcher. Credibility refers to the presentation of such faithful descriptions and interpretations that people who have had such an experience can recognise it. Credibility is also established if naïve readers can identify with the experience when reading about it in the report. Devices such as respondent validation (member checking) or triangulation (using multiple data collection methods) are presented as ways of enhancing this (Pope and Mays, 2006b, Guba and Lincoln, 1994). Though I did not seek to provide every participant with a full transcript (this would certainly raise numerous problems in the focus group) the emerging ideas were presented at fora such as the RCGP annual primary care conference. Also, I discussed my interim findings with many of the participants, and all participants were given the option of further comment. Transferability refers to the 'fit' of the emergent theory to the data, and to its applicability in other contexts. A rich account provides others with a database for making judgments about the possible transferability of findings. Confirmability refers to the freedom from bias (such as from personal values or theoretical inclinations) in the research process and study findings. Guba and Lincoln (1994) also propose criteria of authenticity and raise issues concerning the political impact of research:

1. 'Fairness' has also been referred to as fair dealing (Mays and Pope 2008: 90). Are different viewpoints in the setting fairly represented? This concept is arguably built into the need to seek out cases which do not fit when sampling for this study.
2. Ontological authenticity refers to whether the research helps possible participants better understand their social world.

3. Educative authenticity refers to whether the research helps members better appreciate the perspectives of other members of their social setting.
4. Catalytic authenticity asks if the research acts as a stimulus for members to act to change their circumstances.
5. Tactical authenticity asks if the research empowers members to take steps necessary for engaging in action.

GPs qua participants might not be perceived as the 'underdogs struggling against a dominant views of powerful elites' which is a preoccupation for much social science research (Mays and Pope 2008: 90). However, the above concepts of authenticity come across as thought provoking and laudable.

Reflexivity

The relationship between the researcher and the researched has been subject to debate and study in qualitative research (Coffey, 2002). Particularly perennial issues have been over-familiarity and the effect of context on relationships which are formed in the field. At the time when this thesis is being conceived and written I am a practising UK General Practitioner, who is involved (albeit at a junior level) with undergraduate and postgraduate professional education, and who contributes to academic literature with respect to medical and general practice ethics. Whether or not it helps to be one in order to know one, I chose to venture into the domains of academia, education, and practice with regard to clinical ethics and GP ethics. In a sense, I am both a native and a cartographer in the same metaphorical territory. In another sense I have been seeking social and intellectual capital in order to build the

Bordieusian habitus of a credible academic in the field of primary care (General practice) ethics, whilst at the same time studying the content and boundaries of that territory.

Reflexivity has possibly become conceived as an advanced declaration of bias. Pope and Mays give declarations of bias normative force. Researchers "...can and should make their personal and intellectual biases plain at the outset of any research reports to enhance the credibility of their findings" (Pope and Mays, 2006b)

Reflexivity is a term derived from ethnomethodology, where it is used to describe the self-organizing character of all interaction so that any action provides for its own context (Seale, 2004), and it has become perhaps over-used in reference to self questioning by a researcher. Pope and Mays use reflexivity to refer to the way in which the researcher and the research process shape the data collected, including the role of prior assumptions and experience (Pope and Mays, 2006b). The reflexive sociologist, according to Bourdieu, must engage in 'sociology of sociology' so as not to unwittingly attribute to the object of observation the characteristics of the subject (Bourdieu and Wacquant, 1992).

Haimes (Haimes, 2002) describes bioethicists : "As individual practitioners of their discipline, however varied their approaches and interests, they are members of professional and other social groupings." Pope and Mays use reflexivity as a benchmark of good qualitative research, "The effects of personal characteristics such as age, gender, social class and professional status... on the data collected and the 'distance' between researcher and those researched also needs to be discussed." I consider myself in the context of professional and other social groupings and how I participate in my chosen field:

1. Participation in Practice

I am a UK trained General Practitioner, having undergone training and assessment using the new MRCGP curriculum and examination. I am also subject to the same ethical duties and revalidation and recertification criteria as all other qualified GPs. Having worked as a salaried GP for a year, I am currently combining work as a locum (freelance) GP with work as an Accident and Emergency GP and as an 'Out of hours' (Evenings and weekends) doctor. Whilst this gives flexibility to do a full-time PhD, it may mean that perhaps I might embody the managerial and leadership aspects of General Practice less than someone who is a partner in a practice. However, I interact socially and professionally with 'regular' GPs.

2. Participation in Professional Education

I have written examination guides for medical students (Papanikitas et al 2006) and for GPs (Papanikitas et al 2008), and during this PhD have been engaged to rewrite a textbook of ethics and sociology, public health and clinical governance. I am also engaged to co-author e-learning in medical ethics and law for GPs and GP trainees (with Professor Brian Hurwitz) for the Royal College of General Practice. A further interaction is involvement with London-based RCGP ethics courses aimed both at trainees and older GPs (With Paquita De Zulueta and John Spicer). I also embody a broader appreciation of medical education through membership of the Academy of Medical Educators and active participation (on committees, running educational and academic meetings, chairing meetings and lecturing) at the Royal Society of Medicine.

3. Participation in Academia

This is perhaps the least developed of the three domains. Whilst registered at King's College London, I have published on ethical topics in peer-reviewed general (Papanikitas, 2009, Papanikitas and Toon, 2011, Papanikitas, 2011a) and specialist (Bahal et al., 2010, Papanikitas and Toon, 2010, Papanikitas et al., 2011) medical journals as well as in an academic specialist journal (Papanikitas 2009c). In the course of the above academic and educational activities I was introduced to a movement by academic GPs to formalize an academic sub-discipline of primary care ethics. Whilst I conducted this study, the group (with my involvement) ran 3 annual conferences, developed a web-based forum, and contributed both to academic literature and other conferences.

Though none of the above domains constitute formal observation for the purposes of the empirical study, they arguably contribute to a 'Sociology of self', possibly even with an element of 'auto-ethnography'. They also arguably contribute to theoretical sensitivity. My junior status within each of the three domains is in one sense a disadvantage: My experience of teaching ethics is limited, and more senior participants have more extensive personal contacts such that snowball sampling may convincingly begin to resemble theoretical sampling. An advantage of my relatively junior status, however, is that I am far less likely to intimidate, or exert undue influence in the recruitment of (or data collection from) participants.

Reflexivity: Academic influences on this study

My exposure to STS theories and methodologies (see chapter 2), I have little doubt, comes from the use of STS methodologies in the analysis of bioethical issues that involve biomedical research and scientists. Whilst my chief interest has always been ethics and the education of doctors, I began this study based in the Centre for Bioethics and Society (CBAS). CBAS was interested in the ethical legal and social issues around human embryonic stem cell research.

My initial supervisors, Professors Steve Wainwright and Clare Williams had themselves made similar transitions from clinical practice into the social science of bioethics. Sadly CBAS moved from King's College London to Brunel University, and half way through the PhD two new supervisors became involved in my project, Professors Alan Cribb and Sharon Gewirtz in the Department of Education and Professional Studies (DEPS). I perceived Professor Cribb to be primarily a philosopher and Professor Gewirtz a Social Scientist. They share an interest in the social understanding of education, and this made them highly appropriate influences. Whilst based in the Department of Education and Professional Studies at King's College London I was exposed to an array of theoretical tools from the sociology of education. The division of education into three patterns of activity, namely: curriculum, pedagogy, and evaluation was one such tool, which I have used to organize the data.

Professors Annette Braunack Mayer and Anne Slowther have been two major influences in thinking about general practice and primary care. Both wrote PhD theses, on General Practice and Primary Care Ethics respectively, which involved a major empirical component. Each has a distinctive approach. Braunack-Mayer asks how GPs do ethics, and what makes a problem ethical using qualitative methods (semi-structured interview) with 18 self-selected Australian GPs (Braunack-Mayer, 1998). Slowther's doctoral thesis uses a combination of interview and vignette-based discussion groups to look at ethical decision-making around rationing (Slowther, 2004). Slowther's study is a qualitative comparison of practice nurse decision-making, GP decision-making and decision-making at the level of the Primary Care Trust. The publications of both Professor Braunack-Mayer and Professor Slowther have also shaped my ideas about what the notional field of ethics as applied to general practice might look like.

Reflexivity: Social Background

I am a caucasian, public school educated, professional heterosexual male. I have been raised as a Roman Catholic, and have lived as a child in England (Oxford) and Greece (Athens). For most of the last ten years I have lived and studied in London, but training as a doctor has taken me to London, Brighton, Hastings, Eastbourne, and Aylesbury. I have no doubt that this experience colours my view of the world. I would also assume that it colours others' views of me as a researcher, as insider or an outsider, with views which are contaminated or enriched by my academic and social background.

Ethical considerations and research governance

This study clearly fell under the definition of research (Jones and Newton, 2012) and therefore was subjected to scrutiny and approved by an ethics committee.⁷ In recent years there has been increasing recognition of the need for ethical regulation of forms of research such as in the social sciences and of activities that have not traditionally been labeled as research (such as medical audit). From an ethical perspective, it is the nature of the study undertaken, and the involvement of participants in the study, that generates the requirement to comply with the principles of ethical conduct, and not the label given to it. In weighing up the risk-benefit balance in research, the following should be taken into account (Slowther et al., 2006a):

- The importance, originality and topicality of the research question
- The scientific validity of the study
- The likelihood of achieving meaningful results—for example, the capacity of the study to recruit adequate numbers

⁷ See Appendices A and B

- The potential impact (on the participants, the local community, the disease group, the global community)
- The potential risks to participants and researchers

In the UK, it is no longer part of the remit of the research ethics committee to evaluate the science of a proposal, but they are required to obtain independent information on the risks and benefits of the proposed research. As this study proposed to obtain qualitative data from UK National Health Service (NHS) GPs 'as doctors,' approval was sought from an NHS research ethics committee (REC). However, because the study was not conducted in any research sites other than King's College London separate site-specific approval was neither required nor sought. Two years into the study and after I had conducted the interviews and focus group, I was forced to change department and supervisors (my initial supervisors moved to another university). The REC maintained its approval and did not ask for any additional actions by me.⁸

The main ethical issues which were considered were:

1. Disclosure of identifiable data of individuals or institutions
2. Disclosure of criminal practices
3. Upsetting participants when discussing difficult ethical decisions
4. Recognisable individuals and institutions in spite of anonymisation

I addressed these issues in the following ways:

- 1) All participants were informed that as part of the process of transcription any data which may identify individuals or persons would be anonymised. Tapes, files and any hard copies of the interview transcripts were stored in a secure locker at the work place of the researcher

⁸ See Appendix B

who acted as custodian for the data. I used a digital voice recorder, so it was possible to store the recordings as encrypted audio files. Only anonymised electronic data were be stored on a password protected personal laptop and home computer as encrypted data. A copy of the data was stored on a password protected and encrypted USB storage device. All contact details were stored as password protected and encrypted data on a university computer. The opinion of the REC was that encryption as well as password-protection were to be regarded as standard data security.

Key data, including: consent forms,⁹ a disc (or password protected data storage device) of transcripts, and the research protocol will be kept in the locked office of the main PhD Supervisor, in a locked filing cabinet, for 7 years, as per King's College London policy. This may be for further analysis by the original researcher. It also allows for subsequent review of the primary data as may be necessary for validation in that there is an audit-trail, should the veracity of any of the data be questioned. Use of the primary interview and discussion group data by others would require further REC approval and consent from participants.¹⁰

2) This study focused on ethical issues and education in General Practice and did not explore any specific criminal practices such as assisted-dying. Given the previous experience of other researchers in these areas it was considered unlikely that any information about criminal acts would be disclosed. However, the interviewees were informed that if this occurred during the interview, the interview would have stopped immediately and confidentiality would no longer have been guaranteed. Specific reference is made to this exception to confidentiality on the information sheet. Participants were reminded prior to the interview or focus group.¹¹

3) Thought was given to the very unlikely event that discussion of ethical conflict in practice caused emotional distress. Participants were informed that in the case of being upset by the

⁹ See Appendices D and E

¹⁰ See Appendix C

¹¹ See Appendices F and G

issues raised in the interview they could end the interview at any time. As the researcher/interviewer/facilitator and a GP I was aware of potential stress associated with discussing these issues. All participants received contact details allowing them to contact me in case of any queries or problems they had that arose from participation. Queries and complaints could also be addressed to the main academic supervisor. Participants experiencing significant emotional distress would have been directed to an appropriate counselling service such as the BMA counselling service for participants who are BMA members. I had no complaints, and no one displayed distress in the interviews or focus group.

4) Given the seniority of some of the participants, there was a possibility that participants might discuss their own involvement with particular problematic or controversial cases which have (for example) received media publicity. If this was the case, it was possible that even an anonymised description of the case (that is, with names and places removed) may still be recognisable by readers of the transcript. Moreover, the number of senior GPs who contribute to academic and educational activities regarding ethics (in the UK) is quite small – which may make them identifiable. I had heard a few of the stories which they told me before the interviews and I heard some of them afterwards. In these cases, care was taken to exclude sections of the transcripts which describe recognisable features of these cases from any publication. One such publication was accepted by the journal, *Clinical Ethics* (Papanikitas, 2011a).

Conclusion

In this chapter I have sought to enhance the validity of my study by describing what I do, how I intend to do it, and why I do it this way. I am conscious of the idea that no social setting is

frozen in time, and that few people will necessarily have the same involvement in the field that I have chosen to study. Nor will they necessarily have access to the same participants.

Two key themes run through this chapter in informing the method. The first and larger theme is the researcher as participant in his chosen field. I have chosen to study academics, educators and practitioners. This is at least in part because these are roles I have to lesser and greater degrees adopted as a GP, a teacher and someone who has begun to contribute to academic literature. Interviews and focus groups are a positive choice of method, based on types of interaction with which my participants are familiar. Though this study does not contain formal observation, I bring my own experiences and my own familiarity with both the relevant professional communities and their bodies of knowledge. I have suggested that having lived as if a participant and speaking the language of my participants enhances my claims to authenticity (Guba and Lincoln, 1994). I have treated the symptoms of over-familiarity by frequently stepping outside the environment being studied and looking in, sometimes using analytical ideas as described in the previous chapter, and frequent discussions with academic supervisors and colleagues who are not GPs, as well as presentations to academic and non-medical colloquia.

The second theme in this chapter is the relationship between theory and method. A cook-book approach has been criticized and may even represent a way in which quantitative traditions limit qualitative creativity. However, a recognizable methodological toolkit is needed for the mandatory research governance approvals. Deviation from methodological tradition is often at a significant cost when research-funding favours studies using established methods.

I have sought to defend my use of personal contacts and networks in selecting from what has been criticized as a convenience sample subject to researcher bias. The use of coding becomes

useful in lending validity to this approach. I selected participants on the basis of theoretical gaps in the data, seeking out negatives (a process which feeds into a sense of fair dealing). An iterative approach to data gathering and data analysis all aim for representativeness of concepts.

Chapter 4: The ethics curriculum in UK general practice

Introduction

In chapter two, I discussed curriculum, pedagogy and evaluation as conceived by Bernstein. Curriculum concerns the knowledge and skills that are or that ought to be taught (Bernstein, 1971). This chapter is about curriculum as an educational concept, rather than any one specific curriculum document. As this thesis is about ethics education in UK mainland general practice, I discuss what counts as valid knowledge for the purpose of ethics education in general practice, and how it comes to be counted as such. In chapter 2 I also referred to Gieryn's concept of boundary work in the context of academic and professional boundaries (Gieryn, 1983, Gieryn, 1999, Jasanoff, 2005). Gieryn described the construction of a boundary between science and varieties of non-science as useful for scientists' pursuits of professional goals: acquisition of intellectual authority and career opportunities; denial of these resources to "pseudoscientists"; and protection of the autonomy of scientific research from political interference. I have used 'boundary work' as a 'sensitising concept' when thinking about ethics as something which is taught and tested but also is used to distinguish good from bad GPs. Boundary work is a relevant concept when considering what shapes a curriculum in the selection of the correct knowledge, skills and attitudes.

A nuanced understanding of how a curriculum develops as well as what it contains can potentially be useful for teachers and learners. For example, Riley et al describe the RCGP curriculum as being relevant to GP trainees, GP educators, public regulators of professional standards and GP academics concerned with understanding and improving GP education. They define a curriculum as something that encompasses all the complex factors that contribute to a comprehensive educational programme, and includes the rationale for learning a topic, the context where learning takes place and the ways in which learning can be achieved (Riley et al., 2007a). Riley et al's description of a curriculum that encompasses rationale and context can thus be read as a kind of educational reflexivity. While Riley et al refer to the entirety of the RCGP curriculum, this chapter considers only the context and rationale of the 'ethics elements' in formal and informal curricula. I explore curriculum in terms of academic and professional ideas about valid knowledge, attitudes and skills concerning ethics. Therefore academic and professional scholarship is reviewed, as well as key institutional curricula. It is also discussed in terms of what the academics, educators and learners themselves might perceive to be relevant knowledge skills and attitudes, and why they might have such perceptions. Consequently this chapter increasingly introduces participant data as well in order to capture a sense of the social forces acting on those who shape curricular elements and those who have to teach and learn them.

The broad concept of curriculum that I consider here will appear initially to mostly focus syllabus content. This is in part because of the categorization of data into chapters that relate to curriculum, pedagogy and evaluation as outlined by Bernstein. The participants described learning about ethics in various ways during their training. I consider the mode of learning, such as reading, classroom teaching or workplace-based learning as forms of pedagogy in the next chapter. The content of learning that the participants describe, such as the theories and

topics that may be taught or learned, should be considered alongside official curricula – this illuminates what I have called the curriculum in translation (see chapter 2).

In this chapter I use the ‘What’ to begin to access the ‘How’ and the ‘Why’ of curriculum as regards ethics for GPs. Consequently, the chapter has multiple starting points, chief among them the reading list in the 2006 RCGP curriculum statement on clinical ethics and values based medicine, and readings suggested by participants in this study and by colleagues with an academic or educational interest in the ethics of general practice. The chapter is not a systematic literature review of general practice ethics or of ethics education in general practice. A simple literature search of ‘ethics’ in ‘general practice education’, is insufficient or possibly inappropriate. This is because much literature of relevance is either not explicitly labeled as ethics, or is published in books, documents internal to organizations, or privately produced materials, and therefore invisible to systematic reviews of literature databases. There is also the problem that such a search spans multiple bodies of literature – not least medical education, medical ethics and general practice. More fundamentally, there is an absence of consensus on what is ‘ethics’ for the purpose of general practice education. On several occasions where I proposed methodological ideas or interim data from the study I was asked how I defined ethics. Dowie and Martin outline the many meanings of the word ‘ethics’ to medical educators, their colleagues and students (see table below).

Different domains called ‘ethics’(Dowie and Martin, 2011a)	
Metaethics	<i>Critical philosophical ethics</i>
Normative ethics	<i>Analysis of theoretical relevances in ethical situations</i>
Morals	<i>Personal, cultural, or faith-based behavioural codes</i>
‘Applied’ ethics	<i>Determinative reasoning correlated with normative ethics</i>
‘Practical’ ethics	<i>Similar to ‘applied’ ethics</i>
Bioethics	<i>Normative and ‘applied’ ethics in biological and life-sciences</i>
Biomedical ethics	<i>Similar to bioethics, with a focus in scientific medicine</i>
Research ethics	<i>‘Applied’ ethics and governance in research</i>
Healthcare ethics	<i>‘Applied’ ethics and governance in healthcare professions</i>

Many of the above meanings of ethics surfaced over the course of the study. However, multiple linked meanings surfaced even before I spoke with participants. Dictionary definitions are also unhelpful in finding a common definition that is meaningful.

The 2009 Collins English dictionary contains the following definitions relating to ethics:

Ethic *n* a moral principle or set of moral values held by an individual or group

Ethical *adj* **1** of or based on system of moral beliefs about right and wrong **2** in accordance with the principles of professional conduct **3** of or relating to ethics

Ethics *p/n* **1** a code of behaviour, esp. or a particular group, profession or individual: business ethics **2** the moral fitness of a decision, course of action etc *n* **3** the study of the moral value of human conduct (Dictionary, 2009)

The above definition contains reference to codes of behavior, groups and professions, and has some use but it simply replaces the term ‘ethical’ with ‘moral’. Moral is a word conflated with ethical, for example Orme-Smith and Spicer in their ethics handbook for GPs appear to use the words ‘ethical’ and ‘moral’ interchangeably, stating that both refer to behaviour that is good or bad and right or wrong (Orme-Smith and Spicer, 2001). In this study I was interested in ethics in its broadest sense and more interested in how domains such as those outlined by Dowie and Martin (above) might connect and overlap.

My definition of ‘Ethics’ was led by social meanings of ethics displayed in the field – for this reason I refer to curriculum statements that are explicitly about ethics as opposed to professionalism or governance. For the broad purpose of this study therefore, ethics broadly concerns the rightness and wrongness of decisions that concern GPs. Ethics education therefore concerns the understanding of personal, professional and societal norms.

Curriculum Documents

Whilst this chapter is about curriculum in a broad sense, curriculum documents are relevant. They are the academic blueprints from which teachers and learners plan to teach and learn and whilst they might not define ethics, they do identify relevant educational content. Current general practitioners (GPs) in the UK may have experienced ethics as a component of formal undergraduate and postgraduate medical curricula. Both undergraduate and postgraduate

curricula are discussed in this chapter, because both undergraduate and postgraduate education form part of GPs professional narratives. In the section below I consider key documents that inform the ethical formation of general practitioners. Chief among these are the consensus statement for undergraduate teaching of medical ethics and the explicit curriculum statement of ethics for GPs. Curriculum statements have a role in signposting the relevant knowledge, skills and attitudes required of learners.

This means the days are gone when a new GP spends week searching fruitlessly for an official opinion on 'what a GP needs to know.' GP trainees can focus their efforts instead on developing the identified core knowledge attitudes, and skills of general practice (Riley et al., 2012).

The book from which the above quotation is taken also recommends itself to GP-trainers, GP-educators, and established GPs undergoing appraisal. It illustrates the idea that curriculum statements can be read and acted upon by both teachers and learners

The undergraduate curriculum and syllabus

The UK's undergraduate curricula are relevant to this thesis. The main reason is that many of the participants, and indeed many current GPs, will have been subject to undergraduate curricula in UK. As I discovered and discuss in the next chapter – the presence of an undergraduate curriculum is potentially appreciated not by UK graduates' testimony but by those who have not been subject to it. The second reason is that many undergraduate medical teachers and architects of those curricula are also involved in postgraduate medical education of GPs or are GPs themselves (this is the case with some of the participants in this study).

Tomorrow's doctors

In 1993, The General Medical Council (GMC) set out requirements for medical ethics and law teaching in the undergraduate medical curriculum. National consensus documents on the content and teaching of medical ethics to medical students claim to be in response to the GMC requirements set down in the document entitled, 'Tomorrow's Doctors'. 'Tomorrow's Doctors' is not necessarily a document that all doctors are intimately familiar with. It arguably influences professional and academic leaders, as well as all others who are charged with the task of delivering undergraduate curricula. In the quotation below Steve Field, chairman of the RCGP at the time, emphasizes the relevance of '*Tomorrow's Doctors*' to medical education.

Field: Since 1993, *Tomorrow's Doctors* has been a major influence on how we prepare future generations of general practitioners. As a foundation for the undergraduate curriculum, the report sets the standards for knowledge, skills, attitudes, and behaviour that medical students should learn at medical schools in the United Kingdom. We need to know what type of doctor the GMC expects medical schools to produce. This point should be stated right at the outset, as is the case in the GMC's *Good Medical Practice* guide. That document says: "Patients need good doctors. Good doctors make the care of their patients their first concern; they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity." (Field, 2009)

It is relevant to know that, at the time of the quotation, Field was a key figure in not only editing the RCGP curriculum, but also in producing learning materials for GP educators. Whilst the quotation above is a thin one (in terms of richness of data) it emphasizes the importance

of 'Tomorrow's Doctors' in medical education. With respect to ethics education, the 2003 version of 'Tomorrow's Doctors' states that:

[Medical] graduates must know about and understand the main ethical and legal issues they will come across. For example, how to:

- make sure that patients' rights are protected
- maintain confidentiality
- deal with issues such as withholding or withdrawing life-prolonging treatment
- provide appropriate care for vulnerable patients
- respond to patients' complaints about their care
- deal appropriately, effectively, and in patients' interests, with problems in the performance, conduct or health of colleagues
- consider the practice of medicine within the context of limited financial resources.

Graduates must understand the principles of good practice set out [the GMC] publication *Seeking patients' consent: the ethical considerations*. These include:

- providing enough information about conditions and possible treatments to allow patients
- to make informed decisions about their care
- responding to questions
- knowing who is the most appropriate person to ask for consent
- finding out about a patient's ability to make their own decisions and to give their consent; and
- statutory requirements that may need to be taken into account.

The earlier (1993) guidance had stated that medical students should have ‘a knowledge and understanding of ethical and legal issues relevant to the practice of medicine’ but did not expand on this except to give a list of expected attitudes. Although ‘Tomorrow’s Doctors,’ was last updated in 2009, participants in this study would have been subject to the 1993 and 2003 versions of this document. The 2003 guidance suggests that all doctors must have sufficient understanding of ethics to deal with pre-defined ethical issues. It also emphasises understanding the GMC document, Good Medical Practice. Its relevance lies in that it places ethics into the undergraduate curriculum and thus creates a mandate for the teaching of ethics at medical school. As I will discuss below, this may have improved the availability and consistency of ethics teaching at medical school.

The consensus statements on ethics and law in the undergraduate curriculum

Some of the participants in this study will have had exposure to aspects of the undergraduate UK medical curriculum that concerned ethics, as well as a defined ethics syllabus. A landmark document in undergraduate medical ethics education in the UK was the 1998 consensus statement by a group of teachers of medical ethics and law (Hope, 1998). The aim of the document was to put ‘flesh on the bones’ on the requirement from the General Medical Council that ethics and law should be part of the undergraduate curriculum (Fenwick et al., 2013). The consensus statement and the documents linked to it represent a core syllabus. Because the 1998 statement may well have shaped the undergraduate experience of participants, I list its main headings below:

1. Informed consent and refusal of treatment
2. Clinical relationships: trust, truthfulness and communications

3. Confidentiality
4. Medical research
5. Human reproduction
6. The new genetics
7. Children
8. Mental disorders and disabilities
9. Life and death, dying and killing
10. Vulnerabilities created by the duties of doctors and students
11. Resource allocation
12. Rights

The explicit inclusion of ethics as a relevant subject in the undergraduate curriculum from the 1990s onwards may not have yet had full effect among the general practice workforce. As subsequent chapters will demonstrate, some GPs qualified as doctors prior to systematic ethics input into medical school curricula in the UK, others may have qualified abroad. Many of the participants in this study qualified prior to the introduction of the above syllabus or outside the UK.

Those of us who graduated prior to implementation of such a syllabus may find ourselves to be relatively undereducated by comparison with our junior colleagues (Spicer 2005: 234).

Spicer writes in reference to the core curriculum in ethics and law for medical students. The under-education he refers to above is rhetorical –he has an MA in medical law and ethics, teaches the subject to GPs and is involved in organizing local education for trainees and

medical students as well as having co-authored a number of books on medical ethics and law. He is making a point in solidarity with colleagues of his generation, however. Many ethics enthusiasts tell stories of minimal presence of ethics in their curricula – and note its emphasis on manners rather than morals.

At one time people thought medical ethics consisted of medical etiquette, for example, not criticizing colleagues or working with unlicensed practitioners, taking the precautions needed to avoid falling foul of the General Medical Council (GMC), and not advertising, doing abortions or engaging in sexual liaisons with patients (Toon, 2007).

Secondly, even if it has improved considerably, the thematic content of the consensus statements on undergraduate teaching in medical ethics is slightly biased towards secondary and tertiary care (specialized and subspecialized hospital medicine). In particular many of the issues around informed consent, medical research, reproduction, genetics and end of life decision-making may be slanted towards the hospital setting.

Both original (Hope, 1998) and revised consensus statements (Stirrat et al., 2010) are published in the Journal of Medical Ethics (JME). Not only is the JME *the* main academic peer-reviewed medical ethics journal in the UK but it is also part owned by the Institute of Medical Ethics. Publication of the curriculum statements in this journal represents a level of academic validation that is not demonstrated by postgraduate curricula.

The Foundation Programme (Formerly the House Officer years)

In the next chapter I have included participants' descriptions of ethics teaching and learning during the time which they spent as junior doctors in hospital. Junior doctors' training in the UK has changed dramatically during the professional lives of current GPs and GP trainees. I will not dwell on these changes except to mention the most obvious point. Previously UK graduates were obliged to do one year as a pre-registration house officer (PRHO) before committing to training as a GP. Since 2005, all doctors work for a two-year period as a junior doctor before commencing onto a specialist training programme such as a GP vocational training scheme (GPVTS). This two year period is referred to as the Foundation Programme, and the term PRHO has been replaced by Foundation Year 1 and 2 (FY1 and FY2). During this period trainees are closely supervised as part of team which is led by a consultant. They also have to demonstrate a number of competencies and record these in an electronic e-portfolio.

Whilst the actual teaching of ethics during this period of training has been unmentioned or described by participants as virtually non-existent, it is now an explicit component of the UK Foundation Programme Curriculum (2012). This curriculum sets out the framework for educational progression that will support the first two years of progressions after graduation from medical school. This is included with the sections on undergraduate curricula, because foundation year doctors are 'quasi-students' who have yet to commit to a particular training pathway within medicine. In this curriculum, section four is entitled, 'Ethical and legal issues.' Explicit subheadings in this section are: Medical ethical principles and confidentiality, legal framework of medical practice, and comprehension of outside bodies to professional life. Other topics in the Foundation Curriculum integrate ethics and law, for example, 'Relationships

and communication with patients' includes issues of patient autonomy dignity and consent (Fenwick et al., 2013).

Ethics in the RCGP curriculum

Explicit references to ethics are to be found in the curriculum for GP training in the UK. The RCGP Curriculum was first launched in 2007. This coincided with the RCGP membership examination becoming the qualifying examination for new GPs. All new GPs were now required to pass the exam, including many of the participants in this study. The curriculum was made up of a number of statements. Each statement was coordinated by a GP with particular expertise in that field. Candidates for the Membership of the RCGP were encouraged to read the curriculum statements, and revision materials for the examination remind them of this encouragement (Naidoo, 2008b). The general curriculum administered by the RCGP for a time had a dedicated curriculum statement on clinical ethics and values-based practice (Slowther et al., 2006b).

RCGP Curriculum statement number 3.3 (CS 3.3) on clinical ethics and values-based practice (Slowther et al., 2006b) addressed clinical ethics and values-based medicine as a subset of 'Personal and Professional Responsibilities.' Clinical ethics and values-based practice was considered under this main heading as Statement 3.3 in a series of statements which are

numbered 3.1 to 3.7. These statements also included: Clinical governance, patient safety, promoting equality and valuing diversity, evidence and practice, research and academic activity, and teaching, mentoring and clinical supervision (Slowther et al., 2006b). This was launched as part of the curriculum in 2007, and revised in 2009. It also appeared to privilege one particular style of ethical analysis (Values-based practice), a style that was associated with some of the same academics who had written the curriculum statement. I will discuss values-based practice (also known as values-based medicine, and values in medicine) as a style of philosophical medical ethics later in this chapter.

The RCGP curriculum contained a discrete statement on ethics and values-based practice for the entire time when I was collecting participant data. Whilst it gathered a list of suggested reading, The RCGP curriculum statement (CS 3.3) on ethics attempted to be part of an integrated curriculum (Slowther et al., 2006b):

The knowledge and skills which trainees are expected to acquire are applicable across the whole curriculum, and should be incorporated into all aspects of clinical, managerial and research practice.

The idea behind the broader RCGP curriculum is to define a set of learning outcomes for GP and consequent upon this, to suggest a content of learning. Standards for training are by implication standards common to all GPs. According to “CS 3.3”, every GP should be able to:

- Recognise the ethical dimension of every healthcare encounter
- Understand the nature of values and how they impact on healthcare

- Identify the values that patients, families and members of the healthcare team bring to a specific healthcare decision
- Demonstrate moral reasoning skills in the process of choosing an appropriate course of action or resolving conflicting values
- Demonstrate the knowledge skills and attitudes for effective communication in eliciting and understanding the values of patients, negotiating an acceptable course of action and justifying that course of action
- Demonstrate knowledge of the professional ethical guidelines and legal framework within which healthcare decisions should be made
- Recognise their personal values and how these influence their decision-making.

Essential Feature 2.4 (Justifying and clarifying personal ethics) of the RCGP Curriculum for General Practice training takes in to account the idea that a person's espoused values and their real-life behaviour can often differ. If a GP does not take time to reflect on actions when ethical issues arise in practice, s/he may not be aware if her/his behaviour starts to deviate from the values which s/he supports (Riley B et al 2007: 115). Case-based discussion is also used to explore skills knowledge and attitudes to professional issues. (Deighan 2008: 172)

More recently the RCGP curriculum was simplified. Some curriculum statements (including 3.3) were removed. They were replaced by an overarching statement, "Being a GP" which has links to statements about 'Essential features' (as before) and 'Clinical Examples'. Ethics as a subject is more implicit than explicit in this new configuration. It receives explicit mention in the context of reconciling person-centred care with fairness to others and the broader community and with maintaining good doctor-patient relationships. The overarching statement lists examples of readings rather than a prescriptive syllabus. This includes recognizable sources of

ethical scholarship and guidance. The RCGP Occasional Paper, 'What is good general practice?' (Toon, 1994b) is listed as a resource for 'Person-centered care'. The documents, 'Good medical practice' (General Medical Council, 2006) and 'Good medical practice for general practitioners' (Field and Buckman, 2008) are listed as a resource for 'Community orientation'. Given that 'Good medical practice' provides the foundation for all undergraduate and postgraduate medical education, it would be surprising had it not been mentioned. Perhaps the most surprising reading in the new curriculum statement comprises two books by Seedhouse, 'Ethics: the heart of healthcare' (Seedhouse, 2009) and 'Values-based decision making for caring professions' (Seedhouse, 2005). The Seedhouse texts are offered as resources for the domain, 'Attitudinal features,' which, as with the previous RCGP curriculum covers personal and professional values and ethics. There is no mention of the work that forms the core of statement 3.3. (Petrova et al., 2006), and there is no mention of the four principles of biomedical ethics (Gillon, 1994, Beauchamp and Childress, 2009b). This is startling because values-based (after Fulford et al) and Principle-based approaches are considered to be (respectively) favoured by the RCGP and undergraduate leads for ethics.

The changes to the RCGP curriculum illustrated a theoretical idea as outlined by Bernstein in his discussion of curriculum. A discrete curriculum statement, albeit one that advocated ethics as fundamental to all areas of practice, might be described as a collection. Bernstein describes collection type curricula as highly controlled sets of knowledge with highly defined content. Collections are best exemplified by uni-disciplinary subjects such as chemistry or physics. The advantage of collections is that it is relatively easy for learners to identify what they need to know to pass examinations.

The contribution of academic general practice and primary care

One way in which academic general practice and primary care contribute to either undergraduate or postgraduate medical ethics education is by physically hosting it. The historical tendency for ethics to be situated in philosophy departments but medical ethics and bioethics to be housed in medical schools and law departments has been noted in the bioethics literature.

A good example is the **Unit for the Study of Health Care Ethics at Liverpool University**. The unit is based in the Medical School and the courses are run from the Division of Primary Care.¹² The unit co-ordinates undergraduate and postgraduate ethics teaching within the Faculty of Medicine. The Unit also conducts research into health care ethics, with interests in the areas of reproductive technologies, midwifery ethics, psychiatry and ethics, general practice and community based care and research ethics and social science methodologies in health care ethics. The unit runs modular postgraduate certificate, diploma and MSc courses. The module “Ethics in primary and community health care,” illustrates the enlargement of general practice ethics into primary care ethics:

Health care ethics has frequently neglected to explore the problems faced by those who work outside the hospital setting. These problems are often not dramatic and rarely hit the headlines. Not all the carers involved are professionals: some work for voluntary agencies or care for dependent family members. As far as possible, the course draws on the practical experience of these carers and the content therefore tends to vary from year to year. Typically, students can expect to explore some of the following: ethical issues that are found in general practice, dealing with child abuse, rape, and abuse of the dependent elderly, care in nursing homes, care of drug

¹² <http://www.liv.ac.uk/primcare/teaching/postgradethics.htm>, downloaded 10/3/2011

users, psychiatric care in the community, prison health care, care in the domestic setting, and the shift to care in the community of those previously cared for institutionally and the impact of new government policy.

The above passage illustrates the idea that 'Ethical issues that are found in general practice' can be situated within a wider set. The content of that set 'tends to vary from year to year' depending on the participants in the case of the above course module. It illustrates the idea that there are concerns which may have a different prominence depending on who participates in the discourse. Tailoring ethics discourse to its participants in practice rather than to those in the academy may implicitly endorse the notion that ethics need grounding in context.

Departments require resources to fund staff to teach and undertake research. The following quotation illustrates the role of doing medical ethics (teaching and research) in the expansion of the department of General Practice at Liverpool University.

The department began to expand in the late 1980's with the benefit of... two externally funded lectureships in management (Wellcome) and medical ethics (Health Education Authority). The latter was consolidated into a university-funded post, in part to support our new Masters in medical ethics (McGuinness et al., 2011).

One of the products of this department was a collection of academic essays on ethics in general practice.

Many departments of 'General Practice' in universities appear to be altering their boundaries to encompass primary care. King's College London's department of general practice has evolved into a division of 'Primary Care', part of the Department of Primary Care & Public Health Sciences. This ostensibly 'promotes the discipline of general practice' and thereby improves the 'delivery of primary care.'¹³ General practice is situated within primary care –in the case of KCL, primary care means primary healthcare. If they are to be successful in terms of attracting students, postgraduate educators need to continue to ensure that their programmes reflect the changing landscape of primary care (Tsimtsiou et al., 2010).

This might be seen at first glance as a failure of boundary work, rather like stem cell researchers surrendering some of their freedom to regulators (Wainwright et al 2007). The drive to break down professional boundaries in terms of education and professional ethics finds expression within the enlargement of General Practice, as an academic endeavour, to Primary Care. However, this could also be perceived as an enlargement of an intellectual space that creates a field with boundaries which are more socially and politically 'defensible' by university departments.

In chapter 2 I talked about strains and interests – a broad division of the social forces that might influence the way in which social divisions are created. The idea that that academic and educational activity can be shaped by such forces is illustrated by Dr L in the quotations below. Hosting academic ethics research and teaching and ethicists themselves, whether as temporary or permanent staff within a department can require resources and/or the kudos generated by pre-existing expertise in that department. In the first instance Dr L sets the

¹³ <http://www.kcl.ac.uk/schools/medicine/research/hscr/sections/primarycare/index.html>, downloaded 10/3/2011

interest in being affiliated with an academic department (in this case to teach ethics on an MSc in Primary Care) against the need to be sufficiently compensated for the work.

Dr L: I think... people tend to be interested in the idea of it, kind of rhetoric of it and then when it comes down to the actual, 'Well this is what you need to do and this is how many sessions,' and, you know, maybe the whole sort of murky world of how much you're getting paid and is this sufficient recompense, you know, then it suddenly starts getting sort of very complicated...

Dr L also talked of the prestige that might be associated with being in the same department as particular experts. A number of eminent academic GPs had recently retired in Dr L's region. One might imagine that fledge-ling academics might 'take a gamble' on a less well known or resourced department if there was someone they might be mentored by or publish with.

Dr L: ...I kind of wondered also whether there's a bit of a chicken and egg in the sense that if you, if we had the expertise already in the department, then I think we would be more, it would be easier to attract other people, because there would be some kudos in having kind of connection with the existing expert. But once that kind of expertise goes, then the, those people maybe can't really necessarily align themselves with, or kind of get the kudos from being associated with those experts, because they're sort of no longer there in terms of that particular field, in terms of the ethics.

In Dr L's academic department of primary care, the ethics experts had either retired or moved on and been replaced by permanent staff with other interests. When looking for expertise to buy in on a freelance basis in order to run an MSc module in medical ethics and law, Dr L had

initially looked within the same university. There was some expertise within the university, arising from the medical school and the law department. However, Dr L had been unable to secure expertise from within the university. Those experts that Dr L was able to contact were

either unable to commit to the MSc timetable or their enthusiasm waned when recompense was discussed.

The contributions of General Practice as a profession

In a recent editorial in the British Journal of General Practice, David Misselbrook (GP and ‘senior ethics advisor’ to the journal) articulates the perception by GPs that GPs ‘do ethics’.

David Misselbrook: GPs are sometimes a bit smug about medical ethics. We are the ones trained in ethics, communication skills, and patient-centred medicine — we just are the good guys (Misselbrook, 2012).

However tongue in cheek Misselbrook’s opening line may be, his claim (Misselbrook, 2012), “General Practice has often led the way in medical ethics teaching,” is a serious one. In the quotation below, Dr B described the assumption that GPs should run the relevant course for medical students at his institution.

Dr B: And in a meeting of tutors, who were mainly not GPs, a need was indentified for someone to teach ethics. And somebody turned to me and said, ‘You’re a GP, you can teach ethics,’ which

I always thought was a very interesting assumption ... I think there literally was an assumption, almost a sort of quite a nice, positive sort of stereotype from my hospital based colleague, that GPs did ethics.

Dr B read the comment as an assumption that GPs 'did ethics'. This does not necessarily mean that that there was an assumption that GPs had a special expertise or interest in ethics as a branch of philosophy. Dr B went on to describe this:

Dr B: But I think, I mean this is my fantasy now, but I think, particularly at that point, there would have been a sort of common fantasy among secondary care colleagues, that general practice represented, if you like, the soft end of medicine. The soft, by the soft end, I mean particularly the sort of person oriented bit of medicine.

In the above quotation Dr B described the external perception of the British general practitioner as linked to the 'soft' end of medicine. The question of how best to educate general practitioners, it might be argued, is shaped by the knowledge skills and attitudes that a good GP should have. The Royal College of General Practice in the UK uses the motto 'Scientia cum caritas' (science with caring) to signal the idea that a good GP is sensitive to psycho-social as well as biomedical aspects of the consultation. Moreover, he or she perceives and interprets complex aspects of the consultation in the context of parallel duties to community and society (Toon, 1994b, Toon, 1999b)

There is an extensive literature relating to the role of the general practitioner. According to Jeffreys and Sachs, this is an indication of ambiguities in the recent past concerning such a role (Jeffreys and Sachs, 1983). Much of this literature was based on the agreed premise that GPs already were or were in danger of becoming little more than the sorters of medical wheat from the non-medical chaff. The real problems requiring medical attention (the wheat), it was implied, was increasingly being passed to hospital-based specialists; the chaff consisted either of trivial problems that did not require medical input, or problems for which medical input was inappropriate. The low point of such professional perception is exemplified in Lord Moran's (The president of the Royal College of Physicians) evidence to the 1958 Royal Commission on Doctors' and Dentists' pay. Asked if GPs were on a level with consultants, he responded (a statement which he tried subsequently to retract) that this would be absurd – implying that GPs were doctors who had 'fallen off' a professional ladder and should not be treated like those who had not (Neighbour, 2011).

There was consensus that it was bad for professional morale for GPs to see themselves or be seen by others in this way. Jeffreys and Sachs identify two proffered solutions that emerged: One solution was that GPs should deal with a comprehensive but restricted set of problems and treatments that excluded major surgery and rarer or more specialized investigations and treatments. This solution also excluded social and emotional aspects of practice. The other solution was the task of general practice was to treat every request for help as a legitimate deployment of their diagnostic and therapeutic skills. GPs' standing among their medical peers and among the population at large, as well as their professional gratification would derive from the acknowledgement that they too were specialists. They were possessors of a unique body of knowledge of people in a biological, psychological and social context. There were variations in, and combinations of both camps. Roger Neighbour, himself both an influential figure in

general practice academia and a former president of the RCGP, champions a combination.

Writing in a recent career handbook for general practitioners, he describes three responses to the poor perception of general practice as a discipline: insistence on high clinical standards, the insistence on clinical generalism as a speciality in its own right, and a commitment to excellence in training (Neighbour, 2011).

Texts and participants alike distinguished general practice by reference to hospital medicine. In this way the professional features of the job might shape the content of an ethics curriculum.

Dr C: I think some of... the difference between primary and secondary care ethics... is that general practice and primary care generally is, I would agree with Ian McWhinney when he says it's a disciplining of tasks in which the fundamental characteristic is the relationship with the patient, rather than with the disease or the organ. Whereas most secondary care doctors now are, because the specialists are concerned with the cardiovascular system or the heart or the hips or whatever, the fundamental aspect is different in primary care - is that the relationship is with the patient first and the condition that the patient has, after that. And I think that does make primary care and primary care ethics different from secondary care ethics. I think... the area of judgement becomes more important and much more complex actually, deciding the right thing to do. So I would say that's one fundamental area that would need explanation.

What is striking is how this links with other participants' description of what make General Practice ethically rich: a clinician's gaze that transcends the biomedical and the primacy of interpersonal relationships –ideas Dr B linked to Foucault and Drs M and R linked to the Balint movement.

In discussing moral decision-making by South Australian GPs, Braunack-Mayer suggests that such decision-making is shaped by professional ideology, a 'GP' paradigm. In the description of the RCGP curricula above I mentioned a section that is and has previously been at the core of the curriculum, 'Being a general practitioner'.

The identification of General Practice with a particularly interpersonal approach to medical practice is bound up with the ethic, as well as the ethics, of general practice. It is also identified as something which can be taught back to the rest of medicine by GPs. Dr J make this suggestion in the quotation below.

Dr J: I think it's something that the rest of clinical medicine is kind of catching up with in terms of recognising that actually addressing patients' concerns and how it impacts their life is quite important.

Dr R makes an implicit connection between ethical characteristics of GPs and

Dr R: [Describing a conversation with the author of a book on medical ethics] ...What he keeps on saying is that 'Good GPs do this.' And I keep on saying to him, 'No they don't. Good doctors do this.'

To conclude there has been a perceived qualitative association between general practice and ethics. It may be linked to the professional features with which general practice has become identified. The possible consequence of this is that general practice may not only shape the curriculum for its own practitioners, but lay many of the foundations of ethics for doctors in general, either through involvement in pedagogy, or direct contribution towards the curriculum.

The contributions of philosophical ethics – a broad curriculum and syllabus

This section discusses some of the main styles and approaches in bioethics which are taught at postgraduate level to GPs in training and GPs seeking continuous professional development. These are identified as the main approaches by review of the relevant Curriculum Statement (2004, 2006) and its references as well as recent texts on General Practice Ethics (Orme Smith and Spicer 2001, Rogers and Braunack-Mayer 2009)) and Primary Care Ethics (Bowman and Spicer 2007), and articles aimed directly at GP trainees by RCGP publications (Gillies, 2009) or independently published MRCGP preparation materials. I also refer to two descriptions of ethics teaching of GP trainees that have been published in the general practice education literature (Naidoo, 2008a).

Styles of philosophical medical ethics

Each of the following is intended (in the current document) more as a thumbnail sketch to identify the approach and briefly signify its relevance within ethics teaching, and not as a full discussion of the origins and intrinsic value of the approach.

Principles: Beneficence, Non-Maleficence, Autonomy and Justice

Perhaps the most popular framework that is taught for ethical analysis is the 'Four Ethical Principles' framework (Spicer, 2005). The four principles derive from the Beauchamp and Childress' text *Principles of Biomedical Ethics*. In the UK this method of ethical analysis was championed by Raanan Gillon (notably a GP) in his series of BMJ articles themed 'Philosophical Medical Ethics' and book of the same name. The small book was aimed at practitioners. This in turn led to the publication of 'Principles of Healthcare Ethics,' a larger academic anthology which has the four principles as a linking theme.

The "Four Principles" are acknowledged as important in teaching by leaders of GP education. Deighan describes them as 'often used' (Deighan, 2008). They are cited in CS 3.3. They are also cited in both editions of the 'Condensed curriculum guide' that has been a bestselling handbook with GP trainers and trainees in the UK, even after the removal of CS 3.3 from the formal curriculum itself (Riley et al., 2007a, Riley et al., 2012). Spicer summarises the four principles as follows (2005: 234):

- Autonomy: respect individuals' own choices
- Beneficence: do good

- Non-maleficence: do no harm
- Justice: treat equitably

The principles are intended to be *prima facie*, that is each should be seen as creating a duty unless it conflicts with one of the others. They create a framework and moral language for discussion. In their handbook for GP trainees and GP trainers, Riley et al considered them to be a good foundation for making ethical judgements (Riley et al., 2007a). The principles' strength lies in their intended purpose, to express general norms of 'common morality' (Beauchamp and Childress, 2009a). Riley and colleagues illustrate this idea by reference to the concept of respect for autonomy.

In Western society, patient autonomy has become the overriding ethical principle in most medical decisions although there are still some notable exceptions to this (e.g. in the areas of child protection and euthanasia) (Riley et al., 2007a).

Riley et al highlight the importance of respect for patient autonomy as a key element of 'Patient-centred care' a core competence for GPs to demonstrate. Respecting autonomy involves eliciting and taking into account the patient's ideas, concerns and expectations, and involving patients at all steps of their care, including over how uncertainty is managed.

Riley et al also argue that GPs have a right to refuse to act in a way that they perceive to be against the best interests of their patient. Whilst they do not label this as non-maleficence this is in keeping with a 'Principlist' analysis.

The principles are not necessarily easy or unproblematic to interpret or to apply. Slowther and Parker outline differences in the application of these principles between secondary and primary care, where, for example respect for autonomy involves something broader than a formal consent process. There is little point in continuing a doctor-patient relationship in secondary care if the patient declines treatment or medical advice, whereas the nature of primary care is an ongoing relationship regardless of any one individual treatment decision. Attendance may continue and respect for autonomy may include providing opportunities to revisit such a decision and allow for changing patient views and experiences over time. Two key features are identified by Slowther and Parker, which permit the broadened concept of autonomy: continuity of care and direct access to care. In this context GPs often have knowledge of the patient's situation beyond the immediate clinical problem and may also be caring for other members of the patient's family. They also may have multiple contacts with a patient for a wider range of reasons, not restricted to a single clinical condition. They may share domiciliary care of a housebound patient with members of that patient's family. Decisions made by a patient may have implications for that patient's relatives, to whom a GP may also owe a duty of care. Processes of interpretation are also influenced by cultural or system norms. Outside of the UK, for example, Rogers has highlighted that the concepts of beneficence and autonomy are enacted in different ways by different GPs (Rogers, 2002, Rogers, 1999).

Knight, an MRCGP examiner comments on the widespread use of the 4 principles. It is not clear in her work whether this might be because MRCGP candidates had the 4 principles at medical school and nothing subsequently, or if 'Principlism' is the predominant model for ethical analysis that is taught to both undergraduates and postgraduates.

Knight: In a five-year period of examining, I recollect very few candidates who accessed any ethical theory other than Beauchamp and Childress' four-principle approach in their exploration of ethical dilemmas. Frankly, I find this concerning. Does what has been re-labelled by many as 'The Georgetown mantra' really tick the box of 'ethical theory and the GP registrar'? The four-principle approach is not without challenge, and is an approach which, on analysis, StRs do not perceive that they use in practice.

In a small study submitted as part of an MSc in medical education, Knight found that GP-trainees (StRs) did not use the four principles in everyday ethical decision-making. The implication is that ethical theory is a primarily a tool for passing examinations. I encountered the principles of biomedical ethics in all the learning materials on ethics I could find that were aimed directly at GP trainees (Gillies, 2009, Naidoo, 2008a, Riley et al., 2007b). I comment in the later chapter on ethics assessment (chapter 6) how GPs and GP trainees may see the four principles as synonymous with ethics and vice versa.

Deontology

This stresses the idea of 'duty'. (Greek: deontos, duty; logos, discourse). Whether an act or policy is right or wrong is determined by the action itself rather than the consequences that flow from this action. The 'intentions' of the person in acting are seen as morally relevant. Duties and intentions are often codified into a set of rules. The 'Duties of a doctor' in the document 'Good Medical Practice', which lists what a good doctor should do, is an obvious example of a deontological approach to medical ethics (Gillies 2009: 185).

Good Medical Practice underlies not just the Curriculum Statement on ethics and values based medicine but the entire formal RCGP curriculum (Riley et al., 2007a). The fundamental relevance of Good Medical Practice in all professional aspects of general practice is highlighted in the document 'Good Medical Practice for General Practitioners' (Field and Buckman, 2008). Educators in general practice ethics are keen to dispel the idea of assessments in ethics being only a means to the end of passing the MRCGP examination or as something separate to the real world of general practice (Gillies, 2009).

The provision of healthcare is guided by a framework of legal and ethical principles that are reflected in professional codes of practice. Ethical decision-making and behaviour in clinical practice requires the application and interpretation of ethical and legal principles within a specific context, taking into account the perspectives and values of all concerned (Slowther et al., 2006b). GMC Good Medical Practice (2006), Good Medical Practice for GPs (Field and Buckman, 2008), and BMA Medical Ethics Today (2004, 2012) are cited as examples of professional codes and evidence of moral norms within medicine and General Practice by Curriculum Statement 3.3. Gillies goes so far as to suggest that when preparing for a case-based discussion with a GP-trainer, GP-trainee should think in terms relating to the sub headings in Good Medical Practice (Gillies, 2009). Cases which relate to areas such as good communication, maintaining relationships, consent, confidentiality, truth-telling and working in teams arguably provide particularly good material for reflection (Deighan, 2008). Gillies' suggestion in this particular instance supports the idea of a 'professional' ethic which is duty-based and therefore 'quasi-legal'.

Though values-based ethics was adopted in the RCGP curriculum, quasi-legal ethical regulation remains important and effective in preventing abuses of medical power. The quasi-legal

approach has been described by Fulford et al as one which focuses on patient autonomy and rights-based theories (Fulford et al., 2002). While not denying that protecting patients' rights is important, Fulford et al see the need for a counterpoint to the "growing legalism" in many areas of bioethics. In a reading that is listed on the 2006 RCGP Statement, they question the applicability of quasi legal approaches on several bases. Whilst regulation has an important function in preventing the abuses of power, unrealistic standards present a real danger that well-motivated rule-breaking will permit those self-same abuses. They cite consent procedures in research being so unworkably elaborate that they are consequently ignored by researchers. Good practice can be frustrated by many factors external to the immediate context of good clinical care such as inadequate training and lack of resources, according to Fulford et al, codes should only require particular action when it is within the reasonable power of those concerned (Fulford et al., 2002).

Toon identifies two significant problems linked to an overly deontological approach: public concern about standards of practice and the orientation and values of practitioners, and poor morale among doctors, evidenced by problems in recruitment and retention as well as dissatisfaction among established practitioners. The fall in morale may in part be a consequence of this concern. The fall in morale may also relate to deontological responses to such concern, which by subjecting doctors to an increasingly demanding set of rules and procedures to monitor performance against those rules, are seen as adding to already heavy burdens (Toon, 2007). Deighan relates this back to education:

Each day, physicians fight to express values in the face of reality... Learners need to be made aware of these struggles, to experience them for themselves and to reflect on them. They provide excellent material for case-based discussion (Deighan, 2008).

Quasi-legal ethics also may lead to intrusive regulation on the basis that good practice is far less settled than is sometimes argued. Deighan (listed as a contributor to the RCGP curriculum statement on ethics and values based medicine) writes that “Good Medical Practice tells doctors what to do and why this is important, it does not explain how professionalism should be learned” (Deighan, 2008). Values-based approaches to healthcare ethics has been described as a response to this quasi-legal ethics, aiming for partnership rather than regulation, or facilitating good practice rather than preventing bad (Fulford, Dickenson and Murray 2002).

Values-Based Practice

The re-conceptualisation of General Practice ethics as ‘values-based’ practice is reflected in CS 3.3, which documents that, “This will involve the development of a range of skills and competences that is broader than traditionally associated with medical ethics” (Slowther et al., 2006b). Values-based practice means that consultations with patients should take into account the values of the patient, her family, community and culture. In health education, community engagement and public health programmes, these values as well as the wider values of society are important. GPs should be aware of their own values and how they affect their practice.

Critiques of VBP are not numerous in the literature but they do exist (Brecher, 2011). Whilst some of the educational material available to GP-trainees made reference to VBP (Gillies,

2009), there are instances of it being ignored in both the official trainees' curriculum handbook (Riley et al., 2007b) and independent learning materials for GP trainees (Naidoo, 2008a).

Virtue Theory

Virtue theory is based on the idea that it is the virtues of the good person that are of prime importance in determining what the appropriate course of action is in any situation.

This is in contrast to the focus on duties, as in deontology, or consequences, as in consequentialism and utilitarianism. The emphasis of this approach is therefore on the concept of 'the good doctor'. This of course raises the difficult and interesting problem of determining what a good doctor is (Gillies, 2009). This particular approach has found currency through the publication of two RCGP occasional papers by Peter Toon; *What is good general practice?* Occasional paper no. 65 (1994) and *Towards a philosophy of general practice: a study of the virtuous practitioner*, Occasional paper no. 78 (1999). These two papers set out the author's conception of a philosophy of general practice based on virtue ethics. Virtuist approaches to the study of ethical primary care has a number of champions besides Toon. Iona Heath and John Gillies are both well known GP academics and educators who advocate an approach to medical ethics founded on virtues (Gillies, 2005). They have the added cultural capital of having been the RCGP President and the Chair of the RCGP in Scotland.

Utilitarianism/Consequentialism

Consequentialist theories are based on the idea that the right action in any situation should be based on the consequences of that action. Most influential of these approaches is 'utilitarianism': maximizing utility (the good) understood in various ways including happiness or preference satisfaction. The right action in any situation is, on this account, that which

produces the greatest good for the greatest number (Gillies, 2009). The content of consequentialist ethics for GP ethics education has been summarised by Knight as follows:

This branch allows for the exploration of ethics using consequence as a method of evaluating and making ethical decisions. This would include utilitarianism and QALYs, and would relate to key figures like Jeremy Bentham, John Stuart Mill, John Harris and Peter Singer (Knight, 2007).

The advantage of an explicit discussion of consequentialism is that the ethical component of influential policy ideas, including cost-benefit analysis such as quality adjusted life-years and cost effectiveness in general, can be explored.

Academic ethics and ivory towers

A previous qualitative interview study of how bioethics scholarship affects moral decision-making by GPs has looked at how GPs related ethics to practice. It found that, though the cognitive structures used by GPs in relation to thinking about ethical problems bore resemblance to some of the dominant ways in bioethics of considering ethical problems, the general practitioners did not articulate their cognitive styles with the sophistication and intellectual rigour that bioethicists assert hold for their own work (Braunack-Mayer, 2005, Braunack-Mayer, 2001). Dr C in the quotation below suggests that educators and practitioners are unfamiliar with the jargon and modes of discourse used by academic ethicists.

Dr C: The ethical theory approach to deontology, consequentialism and virtue ethics and there are various other ones that you get as well. But they seem to me to be importing a whole, a whole new system and language and use of words that most GPs and most teachers and trainers in general practice, were completely unfamiliar with.

The philosophical style to which Dr C refers (above) has been perceived as a necessary condition of publishing in medical ethics journals. In the quotation below, Dr S, a participant involved in ethics academia, ethics education *and* general practice suggests that the JME is not orientated to ordinary practitioners. For Dr S academic journals are inaccessible to non-academics.

Dr S: Most of us [GPs] are not academics. Most ethical writing is essentially of an academic standard. And it's not accessible. The JME, let's face it... The Journal of Medical Ethics, you have to be in the trade really to follow. It's not orientated at your average medic... it's got a philosophical style to it. And you have to think your way through those articles quite carefully. Now your average busy GP just *ain't* got time for that, or interest... I remain to be convinced how many people, other than academics, read the BJGP.

AP: And is, so what is it that, I mean is it like a self defeating prophecy? Is it that you're, to be sort of successful in publishing in academic circles is never to be read by your colleagues?

Dr S: I think for most GPs, that's probably true ... And I'm conscious of the fact, when I've written stuff for magazines and journals... that I'm writing at a different level. It's a general audience... But the way one writes for that sort of organ is clearly going to be different for the JME. Or other journals like that.

Publications for ordinary non-academic folk have to be written differently according to Dr S. Success in academic writing for ethics can mean alienation from a general readership.

Below, he describes the academic world as a lovely world to be in, but one which is disconnected from the practitioner.

Dr S: You're in a different world -the academic world. It's a lovely world to be in. But the intersection between academic GP (and not excluding ethical academic GP) and your average GP in the surgery, I think, is not connected ... because if you're in the academic world, particularly associated with an institution, you're in a different world, and arguably shouldn't be a different world, but it is, to a work-a-day healthcare professional.

As chair of the RCGP Ethics committee, Marshall reflects that ethics as a subject is perceived as difficult or academic by ordinary GPs (Marshall, 2010).

There is also a widespread perception that ethics is a difficult subject that is not considered in any formal way by most GPs (Marshall, 2010).

In February 2011 I co-organized a workshop on research in primary healthcare ethics as part of a bigger meeting looking at the state of the field. Attendees at this workshop were asked what they thought of the 'shape' of research in this area. It was striking that 'non-academic' GPs had little idea – the consensus was that 'research' only reached a general audience via an educational event or after simplification via certain writers (Papanikitas et al., 2011).

Is there such a thing as General Practice or Primary Care ethics?

In the sections above I have discussed the influences of academic general practice, the GP profession, and academic philosophical ethics on the ethics curriculum for UK GPs. A related question, however is whether there is a field of study, populated by one or more kind of academic (e.g. philosopher, social scientist or GP) that is concerned with the ethical issues that arise in the primary healthcare context, including the ways in which medical ethics might be nuanced by the context of primary healthcare. As with my discussion concerning academic primary care above, I have noted that both references in the literature and participants study referred to general practice and primary care interchangeably. Sometimes primary care referred to a field with wider professional scope than those issues solely concerning GPs. Sometimes primary care referred to issues solely concerning GPs and it was considered to be synonymous with general practice. When authors such as De Zulueta describe primary care ethics as having a definite place on the bioethics map (De Zulueta 2008) there is an implicit suggestion that primary care ethics is a subset of medical ethics – perhaps more concerned with issues such as confidentiality and local healthcare rationing than with deep brain stimulation or issues around organ transplants.

It is difficult to disentangle the intellectual origins of the academic study of primary care ethics. Braunack-Mayer, for example, distinguishes two approaches: the ‘individual’ account is built on contributions from the general practice literature, and largely concerns issues around the consultation (Braunack-Mayer, 2007). The ‘community’ account draws mainly on writing within the ethics of health promotion and public health.

A different kind of divide is whether the literature originates within the bioethics literature, or the medical (general practice) literature. Braunack-Mayer for example, provides a chapter on 'the ethics of primary healthcare' (Braunack-Mayer, 2007) in 'Principles of healthcare ethics,' whereas Doyal offers a chapter on 'Ethics in primary care,' in 'The Oxford textbook of primary medical care' (Doyal, 2004). Neither is a practicing clinician –Braunack-Mayer has a medical degree but does not practice medicine, and at the time Doyal was an 'Honorary consultant' (but never a doctor) The writings of both permeate literature that might just as easily be accessed by lawyers and philosophers as by GPs.

To some degree, there are explicit connections between the community of scholars and curricula. Academics associated with that body of literature may also be directly involved in writing the books, chapters, articles and formal curriculum statements. An example of a 'GP with particular expertise in that field' who acted as a coordinator for CS 3.3 is Professor Anne Slowther of Warwick University. Other GPs with connections to academia and education include Paquita De Zulueta and John Spicer, both of whom have combined undergraduate and postgraduate teaching with contributions to the literature.

There have been calls aimed at gathering a more explicit body of knowledge and a community of scholars who are interested in the ethical dimensions of primary healthcare.

The primary care ethics described by De Zulueta is very obviously general practice ethics, and the vast majority of authors in 'Primary care ethics' edited by Bowman and Spicer are themselves GPs (Bowman and Spicer, 2007b, De Zulueta, 2008).

Most of my participants who did not address the question spontaneously were asked the following question, “If there were such a thing as a faculty of primary care ethics, what would you imagine that would do?”

Participants identified three educational roles: the education of doctors, the education of the public, and the education of politicians. This is also echoed in participants' sentiments that the organised study of primary care ethics might raise the status of general practice.

When asked what a hypothetical academic centre for primary healthcare ethics might do, participants suggested it might: conduct both theoretical and empirical research, provide consultancy services to academic bodies, regulators and the government, provide educational support to clinicians in primary care as well assistance with problematic cases. Formalised communities of scholarship might also raise the status of the field itself. Participants expressed the sentiment that the 'patient' should be at the centre of any such endeavour but discussions about stakeholder-involvement were left open.

Dr M articulates this particularly well:

Dr M: It would lead to a greater understanding of... empirical research, theoretical research, it would probably mainly be empirical research but it would lead to a greater understanding of the work that we do. I mean GPs... we've not just had difficulty explaining the ethical aspects of their work –of course I'm being unfair because some GPs have articulated very well but even just the nature of our work you know... they haven't articulated it so well so you can see that this

government [New Labour pre 2010 election] have just not understood, you know, it's a very simplistic idea of what we actually do.

Dr M's account implies that general practitioners need to understand the nature and boundaries of their professional role, and politicians and public also need to understand this. A recent survey of GPs, for example, found that an understanding of their own profession was a reason for undertaking an MSc in general practice or primary care (Tsimtsiou et al., 2010). Knowledge informing this understanding needs to come from somewhere.

Others felt that there was no particular need for an academic sub-field, and one participant argued that an organised field represented self-serving by a self-selected group of experts, using expertise to disempower those who did not possess the appropriate technical language.

Some participants raised the possibility that a specialized community of scholars, at least as manifest in a formal department or field of study might be irrelevant or counterproductive. Dr L, the only non-medical participant in the study wondered whether the presence of a department or a specialty might take away the inclination to consider ethical issues.

Dr L: ...I don't see myself as an ethics expert at all, and yet I'm claiming that it's kind of fundamental to everything GPs and everything that we do. And I think sometimes one of the problems of having a department, a specialism, and having a department, it then takes the responsibility off everybody else to think about it. And so therefore if there is a problem... we'll call in our ethics person and they'll kind of deal with it. And the kind of parallel, I haven't really

thought this through... the whole thing about issues around kind of difference and race and gender etc., and the way around kind of addressing that has been the appointment of diversity officers. And so suddenly having that person there, you know, allows you kind of tick the box and sort of say, 'Look, that's kind of now being, being covered.' So I think if there was a department of primary healthcare ethics, I think it would be how they collaborate with all the other specialties because... there is that ethical element there. And you know... the strength of an ethics department would be its, its ability to inform and support what is going on in everyone's practice, rather than kind of become such a sort of speciality that it's perceived as – it becomes an end in itself.

Dr M's particularly enthusiastic response to the idea of a faculty of primary care ethics, makes it easy to see how an 'outsider' might get the idea of enthusiasts creating a field for themselves as an end per se:

Dr M: Well I think it would certainly raise the status of primary care ethics... It would generate more research more this kind of research that you're doing... I think yeah having a centre of you like of Primary Care ethics would certainly raise its profile, raise the understanding would lead to more interesting research... perhaps becoming a discipline in its own right, more literature, more journals... hmmm...

Criteria of success identified by Dr M are in keeping with general markers that an academic field is alive and flourishing. The idea of associating together in dedicated intellectual spaces, be they geographical such as a dedicated centre or department, or intellectual such as community of scholars or a body of literature and dedicated journal with status follows this paradigm.

Conclusion

At the beginning of this chapter (and in chapter 2) I made reference to boundary work as a way of thinking about how knowledge is socially constructed (Gieryn, 1983, Gieryn, 1999). As part of a curriculum for general practice, 'Ethics' is shaped by the concerns of academics, of educators and of practitioners. These three points in the translation of ethics between the classroom and the clinic are all situated in a social context in addition to their relationship to one-another. All three points may influence the curriculum and (as with the rest of the thesis) I have used them as my points of access to the notional field of general practice ethics.

Published documents and participant testimony suggest that the content of ethics in the education of GPs is shaped by academic interests. Intellectual boundaries are linked to education and research. Different conceptions of what is ethical and what is not determine what is researched and taught under the banner of 'ethics.' There is more than one possible kind of academic who might claim the authority to determine what is included in a curriculum. The history of academic general practice has a particular association with the teaching of ethics both to medical students and to GP-trainees. In many medical schools (such as King's College London) this aspect of medical education has been ceded by academic general practice to medical schools and academics from non-clinical disciplines such as law and philosophy. Academic centers for medical ethics have also sprung up in departments of General Practice. However these are in competition with those that have arisen in departments of law, philosophy and social science. Moreover the topics of interest in departments may be resource dependent –if funding for bioethics clusters around biomedical research and hospital dilemmas generated by new technology, there are fewer resources for what scholars have

called the ethics of the ordinary (Papanikitas et al., 2011). Loss of interest in medical ethics as a research topic by academic departments of General Practice or departments of Primary Care could be accompanied by difficulty in accessing teachers of medical ethics with an interest in or experience of general practice.

One of the key observations to have arisen in this chapter is that conceptions of academic 'success' may paradoxically alienate academics from GP. Academics may pursue forms of theoretical rigour and specialized jargon that renders their ideas relatively inaccessible to those without the same qualifications. For example, philosophical approaches to bioethics (and I include medical ethics here) have been accused of lacking a sense of context (Hoeyer, 2006a) and failing to acknowledge the complexity of professional life. By contrast the four principles of biomedical ethics (Beauchamp and Childress, 2009b) have found favour because they represent a common bioethical language for academic and educational discourse. Though the principles are sometimes cited in materials to support medical and general practice curricula as though they were the only way to do ethics, in practice they appear as part of a mix within a professional ethic that is actually heavily influenced by deontological and virtues-based approaches.

The content of ethics education is also shaped by the ideals and identity of general practice as a profession with a professional body. Both academia and profession are subject to social forces that act on an individual level as well as on institutions and wider society. There are professional boundaries at stake here –having 'bespoke' ethical curricula are one way in which GPs maintain their distinctive identity.

Chapter 5: General Practice and Formative Encounters of Ethics

Introduction: Ethical encounters in Education

Chapter 4 looked at the determination and production of appropriate knowledge, skills and attitudes with respect to ethics for general practitioners. In this chapter I have used Bernstein's concept of pedagogy to organise data that relate to the transmission of the relevant knowledge, skills and attitudes (Bernstein, 1971). In other words, I consider the ways in which ethics education is delivered to and ways in which it is received by GPs. Accordingly I have chosen to present the view of both educators and those who are educated in describing the phenomenon of pedagogy. Like Gewirtz and Cribb I define education broadly to include more than just formal processes such as classroom teaching (Gewirtz and Cribb, 2009a). Training in general practice includes recognised elements of workplace-based and self-directed learning, traditionally including an element of apprenticeship.

As well as not restricting discussion to classroom teaching, I have not restricted it to the period during which participants purposefully learn to be GPs. Education in ethics begins well before GP-training commences, and arguably may continue to occur throughout a GP's career. Moreover, many school leavers, medical students, and even newly qualified doctors have yet to consciously decide on a career in general practice. Regardless, their full history of ethics education is relevant in the sum of their knowledge and skill as GPs. This was reflected in the

participant data, and the chapter presents this following a broadly narrative course starting at, or even before, entry to medical school.

GPs in training are supervised and to varying degrees supported in contrast to the relative independence of practice which comes after full qualification as a GP. Even here, however, there are descriptions of formal pedagogic processes such as courses and degrees, as well informal formative processes such as reading, reflection, discussion and mentoring.

Preparation for medical school interviews

None of the participants described preparation to apply for medical school as part of their formation or their medical school interview as a form of assessment. However, this is something which interviewers do discuss with prospective students, and have done in the past. As a 17-year old schoolboy in 1995 I attended one of several conferences in preparation for medical school interviews. Medical ethics was one of the topics covered. See for example this recent observation by Sokol:

Daniel Sokol: I was once paid a neat little sum to give a lecture. It was no keynote address to a distinguished audience in the Caribbean but a talk to 200 or so school leavers who were preparing for medical school interviews. Why an ethicist? Because it is not unusual for 20% of an admissions interview to be about ethics. A good answer displays maturity and nimbleness of thought and lifts the candidate above the rest. A poor one can signal the end of the road or, at best, an uphill struggle for the rest of the interview (Sokol, 2010a).

Medical ethics may be encountered both in books aiming to prepare candidates for medical school, and in courses and sixth form conferences aimed at the same. At the time I was doing

the fieldwork for this thesis I spoke at two sixth-form conferences on the subject of a career in general practice. At both of these there was a lecture and discussion on medical ethics led by Raanan Gillon. Gillon, associated with the introduction of the four principles approach to the UK also writes the ethics chapter in at least 2 editions of, 'A career in medicine – do you have what it takes?' (one of the aforementioned interview preparation books)(Gillon, 2000). Like Sokol in the above quotation (indeed Gillon and Sokol are friends and collaborators) his approach is arguably to give prospective medical students a taste of medical ethics. It may be that none of the participants met engaging luminaries such as Gillon and Sokol or it may be that such preparation was crammed in pupils timetables with other activities such as studying for A-levels finding work experience and reading medical newspaper articles.

Whilst preparation for medical school interviews went unmentioned by participants, two GPs spoke of upbringing by parents and being taught at school:

Dr J: ...I think also if you have a faith in... [tails off] That... [pause] probably that does have an impact on you as well -and probably your upbringing as well. So maybe what you've been taught at school or by your parents. I think those are factors that all have a role to play.

The comment above suggested some moral education derived from parental upbringing or childhood schooling rather than any formal education in philosophical ethics. By contrast Dr G in the quotation below described a charismatic teacher inspiring a life-long interest in philosophy:

Dr G: I mean throughout my life I've been very much interested in ancient history and ancient philosophy, particularly Greek philosophy, partly for reasons to do with a charismatic teacher at school who got me interested in it.

It is difficult to come to conclusions about the comments of Dr J and Dr G set against the absence of comment regarding preparation for medical school. A possible hypothesis might be that Dr J and Dr G have successfully reflected on experiences that mattered to them and somehow connect with what they see as ethics education. It may well be that none of the participants did any preparation for medical school interviews and I did not specifically enquire about this. However it may be also possible that such preparation was seen as more of a superficial exercise in answering interview questions than as part of ethics education.

Ethics education in Medical School

A number of participants made reference to medical school in the context of being taught ethics, generally either as a lecture, or a classroom-based, activity. This section examines participants' reflections on their undergraduate (medical school) experiences of ethics education. The purpose of this is firstly to contrast undergraduate and postgraduate ethics education in the professional narrative of GPs. Secondly, it is to consider whether medical school is the right time for learning about ethics. Some participants wistfully looked back at medical school as the time for learning rather than doing with throwaway comments such as Dr U's below:

AP: Is there any way that you feel that ethics education or ethics support could be improved for your average GP?

Dr U: Okay, yes, right. Well the average GP isn't going to go to medical school any more.

When Dr U (above) made the comment that the average GP is not going 'to go to medical school any more', he drew my attention to the absence of a formal learning environment for

practising GPs, where education (including ethics) might take priority over (or at least be seen as equal to) the everyday concerns of service delivery.

The emphasis on learning and relative lack of service commitment whilst at medical school did not necessarily mean that participants had clear memories of ethics teaching or its contents. Drs Q and O would have been medical students at the roughly the same time though at different medical schools.

Dr Q: I don't remember having lectures on medical ethics, as a medical student. I didn't graduate till... I went to medical school from [early 1990s], so things may have changed since then, but I don't remember going to any lectures on medical ethics.

Just because Dr Q did not recall attending them did not necessarily mean that they did not occur.

Dr O: In terms of formal training, really I only remember a couple of lectures from medical school [...] I do remember a lecturer from [ethics lecturer we have both met]. I remember it being very vague, and I remember – as I say I remember not learning very much from it, rightly or wrongly.

Dr F described medical ethics being an explicit component of a year spent doing an intercalated BSc degree, but could not recall any of the detail of what she learned. None of the participants volunteered any clear narrative memories of learning. Dr O's description suggested that other features may be more memorable than the content of the ethics teaching– in his biographical account he referred both to a particular lecturer, and to the fact that one of the senior figures at the medical school was particularly interested in the subject. Others also describe particular events, activities and people leaving an impression. Dr O described the four principles as the content of his learning, just as Dr D described her UK graduate colleagues being familiar with the four principles.

Was pre-90's medical ethics poorly taught?

In the previous chapter I described the systematization of undergraduate medical ethics education since the 1990s (Hope, 1998). The participants who were more recent graduates did not appear to reflect this systematization of undergraduate ethics teaching in their accounts beyond halting references to the four principles. However I was able to discuss the idea with GPs who had graduated before the 1990s. According to Spicer for example, prior to the late 1990s, medical ethics was taught in medical schools, but in a varied and piecemeal fashion.

John Spicer: Those of us who graduated prior to the implementation of such a syllabus may find ourselves to be relatively undereducated by comparison with our junior colleagues (Spicer, 2005).

Comments such as Spicer's raised the question of whether those who qualified after 1998 would be much more ethically articulate, and more confident in discussing the ethical aspects of medical decisions.

Professor P: And yet that, I think ethics by and large, certainly for my generation was very poorly taught at medical school.

Professor P's generation and those directly preceding it would have been unlikely to have had any significant time devoted to medical ethics in their undergraduate curricula.

At the UK Primary care ethics conference held at the Royal Society of Medicine in London on February 1st 2012, Professor Roger Higgs, a contemporary of Dr G, made reference to one lecture on ethics which amounted to a list of professionally prohibited activities.

Roger Higgs: When I was at medical school at Westminster, we didn't have medical ethics, well we did have one lecture and the geezer said, 'There's the rules of As, no abortion, no advertising,' ...a whole load of things beginning with A, adultery...

Dr G, one of the older participants changed medical school half way through his degree and was able to illustrate a difference in ethos between a London medical school and an Oxbridge college:

I certainly don't remember, at undergraduate level, going to any lectures or tutorials formally entitled 'Ethics.' The fact that I can't remember them doesn't mean that they didn't happen. But I suspect that these things just emerged during the course of clinical case discussion. I suppose is that likely? It probably wouldn't have been at St [Name of Medical School], because that wasn't the sort of hospital that discussed things like that. I did my clinical at [Oxbridge medical school], you know I did my pre-clinical, I don't know what your experience is, but the ethos of the [Oxbridge] undergraduate training is very intensive one to one tutorial discussions with regular supervisors. And I suspect that such ethical discussions as I had would have happened then.

Is this a case of unconscious competence or enculturation?

Two of the participants, Dr D and Dr N qualified as doctors abroad in Asia and Russia respectively. Both describe GP training as their first encounter with taught ethics. In the quotation below Dr D describes the differences that she perceived between herself and those who had studied medicine in the UK.

AP: Could you tell me a little bit about [the VTS Ethics Session]? Do you remember much of it?

Dr D: Well, I'm a foreign graduate, so in my undergraduate days, we didn't talk about medical ethics, nothing, it wasn't there at all. So when I came for my registrar years, all the other registrars knew the four, the breakdown of how you go about ethics. I wasn't aware of that, so learnt about that at that point. And they seemed to know more than I did and they were more ethical than I was...

... But I think the difference between me and a local graduate, they are more aware of ethics and subconsciously they are applying that all the time.

All the other registrars knew 'the four' principles of bioethics, according to Dr D. Given the relative amount of time allocated to the subject, it seems likely that this was as a result of what they learned at medical school than during their hospital attachments. Dr D refers to local graduates being 'more aware' and yet applying ethics subconsciously.

Dr D and Dr N were both reflective individuals who were prepared to discuss their ethics education with a qualitative researcher. Perhaps paradoxically Dr D and Dr N were more aware of ethical issues because they perceived a difference between what they had learned (or not learned) at medical school and what was now expected of them. For example, whilst Dr D perceived herself as less ethical, or 'consciously' incompetent her reflections demonstrated more potential awareness of ethical issues than UK-trained colleagues – who, relatively speaking might, paradoxically, be 'unconsciously' less competent.

Whilst UK graduates were vague about describing the content of their learning It is equally possible that UK graduates progressed to a kind of unconscious competence, as Dr G illustrates with an anatomical analogy:

Dr G: ...as an undergraduate we must have spent at least three weeks, three weeks agonising over the detailed anatomy of the femoral triangle. And having vivas about it, dissecting it and all the rest of it, and learning the anatomy of it, not many years on, all you need to know about the, about the femoral triangle is that you put your finger over the artery and stab medially if you want a vein. That's all you need to know. And at that point, although you probably needed to have been primed to appreciate that, in actual daily practice, most, a huge amount of what you

learnt and agonised over as a student, is either redundant or has become so internalised that you can't see the origins of it any more. And I suspect that quite a lot of ethical thinking is around there as well.

To conclude, I found that participants' descriptions of ethics at medical school in the UK were generally vague or absent. If there was any conscious recall of learning content it either related to the four principles or simply the acknowledgement that such teaching existed. There was no consistency among accounts as to whether ethics was not taught or poorly taught. The existence of either a familiarity with ethical values endorsed by wider culture or the four principles and ethics teaching, was remarked upon by the two participants who had qualified outside Europe. Possibly as outsiders they were able to perceive themselves as making a transition from conscious incompetence to conscious competence.

Hospital induction and postgraduate teaching

Most UK GPs will have spent at least 3 years as a junior doctor in a hospital environment. Medical Ethics is generally taught only briefly, as Sokol illustrates in his British Medical Journal (BMJ) column 'Ethics man.'

Daniel Sokol: Tomorrow I must give a talk to junior doctors about "Essential ethics and law for the junior doctor." This may be the only hour they have on the subject in the entire year. What should be included? (Sokol, 2010b)

Daniel Sokol, an ethicist writing for the BMJ, the weekly medical journal that participants considered to be most widely read, muses on how to impart moral perception. Sokol suggests that the 'hour' is best served by sharing and discussing illustrative and problematic stories.

Sokol's approach is not the norm and perhaps represents the experience of a handful of cohorts of junior doctors over a few years in one particular teaching hospital.

Dr O recalled no formal teaching on ethics and/or law as a junior doctor in hospital, but recalled being made aware of the importance of protection of patient data:

Dr O: Well, I say that, I remember, I remember an induction session by the IT guy. And teaching as if for the first time about the importance of confidentiality, which I felt was rather bizarre.

Sokol illustrates the boredom generated by reference to the routine in the context of junior doctor teaching:

Daniel Sokol: Another "essential" issue is confidentiality. I shall not bore the junior doctors with old sayings about soundproof curtains and indiscreet discussions in the cafeteria (Sokol, 2010b).

The guidance on confidentiality referred to by Dr O above is very much in the vein of 'old sayings about soundproof curtains and indiscrete discussions'. He recognised this as ethical in the context of our discussion rather than just one of the many administrative burdens placed on junior doctors. Dr O described the session as bizarre, chiefly because the idea of protecting patient information seemed so obvious both in terms of the espoused values and the routines. Dr O was the only participant to relate confidentiality to the doctors' mess.

General Practice Vocational Training

According to an article on ethics that appeared in InnoVAIT, the RCGP journal aimed at trainees, trainees are encouraged to participate in well-facilitated small group learning such as often provided on half-day release sessions in the course of a vocational training scheme. They are also urged to consider using tutorials with a GP trainer or educational supervisor to look at specific ethical issues raised by consultations or within a 'hot topic' such as palliative care or the termination of pregnancy (Gillies, 2009).

Certainly 'Ethics and values based medicine' has been a part of the GP curriculum since its inception (Slowther et al., 2006b). There is documentary evidence of formal events built into training schemes before this. In 2001 for example, Molyneux reported his attempts to introduce a formal component of medical ethics to GP-trainee education in the north of England (Molyneux, 2001). On the basis that this formal component had to be delivered within two half-day sessions, he allocated one half day to theory and subdivided this into consequentialism and prima facie ethics (see below). Prima facie (at first sight) ethics refers to the use of principles which are absolute on their own unless there is conflict between principles.

However, participants whose training predated the MRCGP curriculum were more vague about this. The presence of a syllabus does not necessarily mean that it was used. Several participants involved in training were prepared to share their indifference or dislike for the curriculum statement on ethics. Even when adhered to it is one of many statements on the learning expected of a UK GP. Dr D's comment below illustrated this:

Dr D: It was in our syllabus thing, yes ... I think it was the MRCGP syllabus ... Or was it part of our training? I think we just, they had to just touch on it...

Prof Z: But of course in the vocational training courses have lots of ethics in there, discuss things.

But would a typical GPVTS have 'lots of ethics' in a sense of conscious formal encounters with protected time for learning and reflection?

"Day-release" – Classroom-based ethics teaching on the GPVTS

Most of the GPs and GP Trainees I spoke to had a session on medical ethics built into their training. For example they might have one or two full or half-days of teaching dedicated to the subject on their GP vocational training scheme (GPVTS). Professor Z had led GP-registrar teaching on a couple of occasions. Being associated with medical ethics, this was the subject on which he had taught. Many of the GPs involved in academia and education had contributed to formal ethics teaching for qualified doctors specialising in general practice. This was formalised in the GP vocational training schemes (GPVTS). Dr S had coached GP-trainers in this area, Drs B and L had organised a GPVTS.

From the perspective of this study it is be interesting to question what impact the overt education of ethical knowledge, skills and attitudes has on moral decision making by younger GPs. Indeed this question might just as equally be applied to GPs that predate the RCGP curriculum. In this case however GPs have some catching up to do as the curriculum is also a benchmark for appraisal and revalidation of qualified as well as training GPs.

Dr D provides the clearest description of such a formal event.

Dr D: I was a GP registrar, and in a nice safe setting, you know ... One was an Egyptian, two of us were Indians, trained. The rest were all English graduates. And it went on pretty well, I think. Well, for me at least. The rest looked a little bit bored, I guess they knew what it was all about, but I felt it ...

Dr D describes a 'safe setting'. The formative environment is generally perceived as safe by participants. As Dr D comments elsewhere, those who had graduated in the UK looked a little bored. Dr D guessed that they knew what it was about, or as with Dr G's anatomical analogy above, what was being discussed may simply have appeared self-evident. Dr D goes on to describe a fairly typical day release session on medical ethics.

Dr D: They gave us some leaflets after that ... It was more like case-based discussion. They gave us this whole list of situations and broke us into groups and saw how we actually allocated the money or funding or something. That was the exercise initially, and then it was, they asked us why we did that, and things like that, you know – pregnant women, HIV, blah, blah, blah. Those kind of things. And then they used that as a training tool, I guess, and then asked us about the – I still for the life of me can't remember it. I know it's four, and asked us how to break down the ethics whatever. That's how we did that.

Dr D described her GPVTS organisers just having to 'touch on' ethics. Like a session for hospital trainees, a one-off session was easily missed. Dr F thought she had missed the ethics teaching provided on her training scheme, a definite drawback to providing training as a one-off event, such as the 'hour' provided for junior doctors that is alluded to by Sokol (2010). Furthermore the session on 'Ethics' is easily missed for a number of reasons. Dr F illustrates missing the relevant session whilst a senior house officer (SHO) in hospital.

AP: Okay, and in the GP training, is there any kind of sort of built in, 'Today we're going to talk about ethics'?

Dr F: I think on my VTS, yes there's been a session, when I was an SHO. But I didn't go to it, because we couldn't go to one of them.

Despite giving a relatively clear account of GPVTS training in ethics, Dr D found it difficult to recall specifics. Dr O could not recall any specifics from his or indeed if he had one. Dr Q identified ethics with preparation for examinations as did Dr O.

AP: Okay, and then sort of getting on to general practice training day release, how did medical ethics come up there for you?

Dr O: I don't think I really will remember any specifics. Again, and probably this blurs in with sort of one of your next questions, again it probably comes more into the context of exam preparation, preparation for the MRCGP.

Participants' encounters with ethics in the GPVTS could be summarised as being both essential and yet negotiable. How much GP trainees get on ethics from their GPVTS appears contingent on their perceived needs. It is a part of the curriculum, and as with undergraduate teaching the four principles of bioethics are taught.

Clinic-based medical ethics training in the GPVTS

In the UK, there are two main aspects to the training of GPs. Trainees have some time allocated for 'classroom' activities such as formal courses, classes and group exercises. The other aspect to GP education is a form of apprenticeship, where GP-trainees take on increasing responsibility within a 'training practice,' supervised by a GP-trainer. Dr O (below) mentions the 'day-release' course but links ethics with conversations with peers and his trainer.

Dr O: Less formal training – I guess really the GP training, the last year of GP training, the GP reg [registrar] year, in terms of the day release course and then in terms of, you know, conversations with my trainer, and since then conversations with peers, you know, I guess ethics came into many of those conversations.

Dr U illustrates the trainer's side of this discussion.

Dr U: ...obviously as a trainer, this was one of the subjects I used to discuss with my registrars, but only as a jobbing GP and my understanding of medical ethics. I've taken no higher qualifications in it, and apart from reading one or two textbooks in order to be competent as a trainer, nothing special.

Whilst there is no mandatory training in ethics that GP trainers are required to undergo, during the period that I was gathering data, I was invited to speak at two GP trainers' groups. Dr S also provided me with an outline of his lesson plan for similar activities.

Until the end of the 20th century, professional ethics might have been seen as something that would be learned by subconsciously by modelling. Campbell and Higgs describe this, "To some 'ethics' means little more than etiquette, the accepted conventions of a social role. 'Medical ethics' in this sense means correct professional behaviour which is passed from older to younger practitioners by precept and example. (Some have called this the mystical infusion view!)" (Campbell and Higgs, 1982c)

Dr B: But for most trainees, I think you've got to go through the sort of thinking it out process, before it will become intuitive at a deeper level. Some people will always have to think it out. And some people will just act intuitively, which, if they've been taught well or even modelled well, will be okay. But I think that's mildly dangerous because the problem with just modelling obviously is that you'll pick up the bad habits as well as the good of your mentor and you won't go beyond your mentor. So my aim, with any trainee would be to enable them, themselves, to come to a view as to what are my bad habits and my good habits, and to do better than me. But I acknowledge that some trainees actually learn primarily by modelling.

Hope et al suggest that, "The apprenticeship method of medical education can make doctors blind to these ethical components: the ethical and scientific components of the decisions are not separated or separately assessed but remain entwined within the notion of clinical decision-making" (Hope et al., 2008).

There may even be an intolerance of ethics teaching based on the notion that discussion of medical ethics may over-exaggerate or unnecessarily prolong moral deliberation. Campbell and Higgs quote a hospital consultant, “When people start talking about ethics I reach for the golf clubs,” to illustrate a view that professionals pick up ethics as they go along and that it is a matter of common sense and experience (Campbell and Higgs, 1982a). This may result in the idea that ethical issues are somehow un-contentious or that because there is no perceived dilemma that there is nothing to discuss or understand (Molyneux, 2001). The need that responsible decision-making should consciously incorporate the ethical dimension is echoed by Christie and Hoffmaster (Hoffmaster et al., 1982).

Some of these issues may have been neglected because they are commonplace and uncontroversial, others because they have been masquerading for too long as “medical” or “clinical” decisions. A number of readers may have difficulty discerning any ethical questions in certain types of cases... seeing them strictly as medical problems. We want to remove these blinders, for responsible decisions can only be made if the personal and the social, as well as the medical dimensions of issues are recognised (Hoffmaster et al., 1982).

Gillies suggest that trainees do see areas of ethical difficulty but only when they cause difficulty or when there is a difference of values that is evident, perhaps through disagreement over a decision.

All trainees are continually exposed to areas of ethical difficulty throughout their training; the important thing is to be aware of them... [Trainees] tend to notice values only when they are diverse or in conflict (Gillies, 2009).

This may well be why some trainees perceive that their education is inadequate. In the comment below Dr F voiced her fear that she will not be prepared for ethical issues that arise.

Dr F: I'm actually worried, I'm scared, although I've still got six months to go, I'm worried that I'm going to end up being a GP come August and there will be ethical issues that will sort of – that will come my way, and I'm not going to know what to do.

Awareness is a necessary first step in ethics education for practice. However, if trainees consider ethics only to be what has been identified as problematic by lists of hot topics, or by what they have encountered as a problem then there may be instances of new issue arising where they are unprepared, unless they have a way of dealing with new problems that arise.

The conscious analysis of ethical features in practice is recognised in the Royal College of General Practitioners curriculum. It is categorised as an 'essential application feature'. The essential application features are described as important factors that are always present in the background of a consultation and exert a strong effect on how a GP's knowledge and skills are applied in everyday practice. As an essential application feature, ethics comes under the heading of, 'Attitudinal aspects of care,' quoted below from page 111 of the RCGP Condensed Curriculum Guide (Riley et al., 2007a):

Riley et al: This requires a GP to be aware of his or her own attitudes and capabilities; the ability to identify ethical aspects of clinical practice and to understand his or her own personal ethics and values; achieving a good balance between work and private life.

In the 'new curriculum', the RCGP encourages active learning of professionalism using approaches such as: apprenticeship, theory, technique or skills based approaches and reflective practice. Apprenticeship is used to convey caring, commitment, altruism, tolerance, service, compassion and integrity. Theory can be used for codes of practice, the law and ethical frameworks. Reflective practice may be used to improve clinical judgement and self-awareness (Deighan, 2008).

Whilst Dr B was keen to remind me that the ability to work through an ethical issue consciously and methodically was not necessary to be a good or virtuous GP, it was desirable for a GP trainer.

Dr B: As I say, you know, to sort of set up the sort of rather simplistic notion of one of my partners [in practice], I'm quite sure he wouldn't describe the process of ethical reasoning that we've had in the last five minutes, in any way, shape or form, in the manner that I have. But I suspect that he would be more skilled at when to intervene rightly and when not to intervene in somebody with domestic violence problems, than I would be.

... And certainly it would be true that my partner would be a very, very good role model, but would be a less good teacher for, for [the] majority of learners who do not rely wholly upon modelling in which to learn.

One way awareness of this has been raised in GP-training is with random case analysis focussing on ethical issues, or by asking a GP trainee to keep an 'ethics diary' for a week – noting down issues that made him/her stop and think (Deighan, 2008). Gillies comments that GP trainees are encouraged to enter their thoughts on a topic or case which raised interesting ethical issues in to their e-portfolio as comments on a clinical encounter, professional conversation, significant event analysis or other category of log entry (Gillies, 2009).

Ethics education for ethics educators

The expectation to professionalise medical ethics teaching is not new. The following quotation is Gillon's commentary in the *Journal of Medical Ethics* on the Pond Report of 1987 (Gillon, 1987). The Pond Report was commissioned by the Institute of Medical Ethics and followed on from a General Medical Council conference in 1984 on medical ethics teaching, and a call from

the British Medical Association for rigorous teaching of the subject and a curriculum for medical schools.

Raanan Gillon: Interested medical teachers are encouraged to undertake further study of medical ethics through appropriate courses and/or to involve themselves in co-teaching with non-medical teachers from the 'analytic disciplines' of moral philosophy, moral theology and law, as well as nurses, social workers, chaplains and other medical-related professionals and also with 'representatives of the articulate and considered lay opinion'.

Whilst the Pond Report mostly concerned the teaching of medical undergraduates, it also commented on the need for improved postgraduate education (Gillon, 1987).

A number of participants in this study described taking formal courses and qualification in medical ethics and related subjects in relation to teaching medical ethics. Sometime this followed on from a pre-existing teaching commitment and a perceived educational need. Sometimes the opportunity to teach ethics sprang from a pre-existing intellectual interest. Formal qualifications in medical ethics and related subjects described by participants included university degrees as well as non-degree courses, provided by universities, professional organizations and learned societies.¹⁴

For example, Dr B described qualifications in retrospect. Dr B is an experienced GP-educator, and was involved in the undergraduate teaching at a medical school. However he did not initially have qualifications in the ethics per se. In the comment below he describes advanced qualification (verb) as a route to professional expertise.

¹⁴ Learned societies are non-university institutions, examples include the Royal Society of Medicine and the Society of Apothecaries of London

Dr B: But, as time went by, I thought I ought to perhaps learn more about it. To be fair, I've always had an interest in Philosophy and the Philosophy of Medicine. I did quite a bit of self directed study in that as an undergraduate, nothing to do with my formal medical course. So there was a certain sort of match with that. I always did a bit of self directed study in reading around ethics and eventually, about ten years ago, I did a course called the DPMSA, the Diploma in the Philosophy of Medicine of the Society of Apothecaries. That led me to deepen my interest in ethics. I then went off to do an MA in Philosophy at [London University].

The Worshipful Society of Apothecaries of London, is what one might term a 'Learned society'. It is one of London's old city livery companies, but has within its organisation faculties that deliver medically-related accredited courses, lectures and occasionally conferences. Its faculty of History and Philosophy is particularly active. I did the DPMSA course and examination myself in 2001 and have taught on it in 2013.

Dr S illustrated a prospective approach. A qualification in medical law and ethics led to opportunities to lecture in the subject. Dr S already had accreditation in medical education.

Dr S: I did a Masters Level qualification in medical law and ethics [at a specified university] about ten odd years ago, which was part of, that was my choice if you like, of professional development, when an opportunity arose to get time out of practice and funded education so I chose to do that, which I'd never done before ever, either as an undergraduate or postgraduate. But it seemed to be interesting at the time and I think it's shown itself to be so -since doing this degree. And that was my way into a world which, as I said, I really had no previous experience of before, which was absolutely fascinating, and I was lucky enough to get a lecturer position a couple of years after that, and I've carried it on ever since.

All of the 'Ethics educators' who I spoke with described a vocational aspect to the qualifications. For example, Professor Y 'enjoyed' (her word) the law in MA in medical law and ethics that she went on to do an LLM in the same subject. She was clear about where she did both qualifications, as both institutions carried the prestige of being associated with particular leaders in academic field of medical ethics and law.

Whilst structural concerns might shape a choice of course or degree, there was also an element of personal choice, or heterogeneity. Dr B was one of several participants who preferred to obtain a philosophical than a legal degree.

Dr B: Well I mean there are a million and one Masters courses as you say. My impression of those is that an awful lot of those are courses in medical ethics and the law. And I personally don't like those so much, because in a course like that, when push comes to shove, people tend to say, 'Well what does the law say?'

Many of the educators among my participants, including Prof Z, Prof Y, Dr B, Dr C, Dr S, and Dr M taught or had taught ethics to both undergraduates (medical students) and postgraduates (Junior hospital-doctors, GPs or GP trainees). Like Dr C below, they all made use of the content of their learning in teaching. The course which Dr C refers to is a 1-week intensive ethics course run by Professor Raanan Gillon at Imperial College. I attended this course myself in 2009. At the time I observed that my co-participants and I from the UK were mainly either involved in education or resource-allocation activities.

Dr C: I still do some undergrad teaching with [University Professor in Medical Ethics]. I rely quite heavily on material that I got during doing the Masters and the one week's ethics course in London, in fact, and just some general reading around the subject.

Only Dr C described co-teaching of the kind referred to in Gillon's commentary on the Pond Report above. However there are some published instances of a GP and a philosopher publishing books and articles together such as Roger Higgs (GP) and Alastair Campbell (philosopher) or Brian Hurwitz (GP) and Len Doyal (Philosopher) (Campbell and Higgs, 1982b, Doyal and Hurwitz, 1987).

Informal formative encounters with ethics

This section refers to the informal formative encounters with ethics described by the participants. It is immediately striking that participants appear to have less to say. Informal encounters such as conversations with colleagues over a coffee, the influence of mentors and personal reading are perceived as under threat unless in response to a doctors' educational need. The key threat is the lack of time – an issue raised under other headings in this chapter. Professor Y cements the idea that an academic environment allows thinking time in a way that practice does not.

Professor Y: But where is the time? This is what I say. I was in academic general practice for many years, and you've got time to think then.

By contrast there is less time for reflection in the 'real' world where service provision is the main focus of a GP's activity, and this may itself be under pressure.

Informal encounters with ethics education, that is, outside the confines of a timetabled course or a training programme fell into two categories in my discussions with participants – discussion and reading.

Discussion

A group discussion within the confines of a GP Surgery or a GP learning set of some kind was another formative encounter with ethics. Medical ethics, Gillies argues, is not a subject which can be taught and learned by dissemination of fact, but requires discussion and argument (Gillies, 2009). This may be contrasted with the traditional structure of UK General Practice, which involves most GPs working independently, making decisions about patient care without the monitoring and support structures provided by the hospital setting. This may result in a relative lack of awareness of ethical issues arising in practice, fewer opportunities for discussion with colleagues, and difficulties in providing ethics support. Slowther and Parker argue that the geographical dispersal of GPs and their places of work is a barrier to ethics referral (Slowther and Parker, 2007). Here I discuss discussion as a form of pedagogy. Dr Y illustrates the relative lack of formal educational presentations in practice.

Prof Y: And occasionally we have a, not a significant event, but a topic. I can't remember what the last one was actually, but that's quite rare. Usually it's informal discussions.

Dr B also commented on the increasing rarity of discussions around the patient rather than some aspect of the GP surgery as a business.

Dr B: ...we were reflecting as a practice the other day that 10 years ago when we met over coffee in a sort of haphazard way every day and in our weekly team meetings we spent most of our time –well certainly a very large chunk of our time discussing individual cases, whereas we now spend most of our time on practice administration and [quality and outcomes framework targets]...

Dr M described significant event analysis as a forum where ethical issues might be recognized. In a sense there are two key reasons why ethical discussion might arise in a significant event. Significant-event analysis is generally done as a group learning exercise where something has either gone wrong, or had the potential to go wrong –a 'near miss'. Conflict, tragedy and

wrong decisions are present. Consequently such cases might not only have a legal and clinical component but also an ethical one. Significant event meetings are encouraged in general practice as a way of avoiding future (potentially costly) adverse events, and are also encouraged as part of individual GPs' commitments in terms of demonstrating quality assurance for annual appraisal. In theory at least the aim is to improve a service rather than blame one or more individuals.

AP: Are you saying that ethical problems are usually raised under other banners?

DR M: Yeah. Significant event analysis. For example there used to be weekly management meetings in the practice where I worked and quite often there would be one or two ethical, real you know ethical problems would be brought to be discussed in the group.

Dr M used child protection concerns or concerns about domestic violence as an example of an ethical discussion that might be raised in a significant event meeting. Rogers and Braunack-Mayer, use the same example to illustrate the overlap between clinical, legal and ethical decision-making (Rogers and Braunack-Mayer, 2010). In his call for ethics education and advice in primary care Peile suggests that significant event meetings are an excellent forum in which to host an ethical discussion (Peile, 2001).

Dr S added that it is worthwhile for a discussion group to have someone with ethical expertise.

Dr S: That's a good one. The first step surely is to have a forum in which you can discuss it. So that could be a significant-event type discussion kind of meeting. So to actually gather all the doctors in the same place and the same time to discuss stuff, hot stuff that's going on. And I think it's easier to say than do and practices have to make an effort to make that happen. To then be able to make their discussion go beyond a rather superficial one let's say may take somebody with expertise. I think that is one of the ways in which my practice uses me.

Doyal advocates regular fora where GPs can discuss problems, and where the responsibility for strategies for their optimal resolution can be shared (Doyal, 1999). He also describes some moral indeterminacy as irresolvable at the 'level of general practice,' and cautions against overestimating the importance of collective reason. Sharing a decision does not necessarily mean a better decision is made – for Doyal the best kind of decision involves the best kind of reasoning – this ties in with the idea that discussion might involve others with experience of the issues or expert facilitators.

Some of the above groups might be perceived as adversarial in nature, for example significant event analysis may occur after an adverse event or near-miss. Moreover discussion of the medicine may eclipse the human and more arguably ethical aspects of such a discussion. It is not a surprise that ethical and legal aspects of practice may be raised in Balint groups.

Dr R: I think one of the most influential things on my professional thinking was the fact that I found myself when I entered training, right in a nexus of Balint thinking and Balint creativity. My trainer was a member of a number of Balint research groups. There was a regular Balint group as part of my training every Wednesday afternoon for three years. I later worked with another course organiser who was [involved in] the Balint society and so forth. And so there was a sort of a network, a very strong subculture of that approach to the doctor-patient relationship.

Though Dr R was keen to point out that discussing ethics was not the intended function of Balint groups, the unique quality of the Balint group method is that it provides a safe environment for doctors to examine the nature of their work from a de-medicalised perspective. The group members are encouraged to examine the process of the consultation. At present in the UK, Balint group work is almost completely confined to educational programmes that are linked to GP training (Dicker, 2007).

Reading about medical ethics

I have considered ethical readings in the context of curriculum. Now I consider them as a pedagogic medium. The quotation below is from an article published in the journal, *Education for Primary Care*, by Rhona Knight, a GP who served both as an MRCGP examiner and a member of the RCGP ethics committee. She considers what speciality trainees (StRs) in general practice might read.

Good resources are accessible for StRs to increase their understanding of medical ethics. As well as more generic texts, there are some specifically aimed at primary healthcare. These include: Peter Toon's Occasional Paper on virtue ethics; John Spicer and Anne Orme-Smith's book on Ethics in General Practice; Fulford, Dickenson and Murray's book Healthcare Ethics and Human Values (Knight).

The texts identified by Knight are very different kinds of book. Toon's Occasional Paper is an argument for Aristotelian Virtue Ethics as the underlying philosophy for General Practice. Spicer and Orme-Smith's book is a work-book with simplified theory and case-studies – theirs is probably the most accessible to trainees. The text by Fulford et al is an edited academic anthology. Having sampled the above texts myself, it seems evident that they might be accessed in response to a need.

Dr S: As ever, learning, or reading around happens in response to need and if you don't have a need of ethical theory, or if you perceive yourself not to have a need, then you don't do it very much ...

Dr S described reading related to ethics in medicine as like a reaching into a "Quiver full of arrows". As well as ethics texts, Dr S's approach at times was to use literary references to address an overtly ethical learning need. Dr S for example makes reference to 'The Spirit catches you and you fall down' as one of the books he recommends. This novel is about the issues faced by an immigrant family in dealing with western medical services. I asked Dr S

following the interview if the quiver-full of arrows was conscious reference, either to one of the Psalms from the Bible or to a collection of short stories by Jeffrey Archer. It was neither, just a useful simile. Other ethics enthusiasts among my participants accessed a wide range of printed scholarship. Dr B and Dr M referred to a smorgasbord of scholarly works by a range of authors including Plato, Foucault and Holm. This informed their own work, but they were not averse to sharing insights which they had gleaned from reading.

The following entry on ethics in a revision-guide for GP-Trainees seems fairly dismissive of academic scholarship (Mead, 1995).

Best learnt by example. The BMA publish *The Handbook of Medical ethics* which is worth reading. Reading a book takes time, and whilst participants did not state that books physical availability was an issue – I found that, as an ethics teacher in a university that online resources were much more likely to be accessed and read. Books in the library had the potential to be unavailable and the same books were expensive to buy.

Non academics described a lack of time for scholarly reading whilst at the same time advocating the use of and bemoaning the lack of scholarly work on ethics. In the quotation below Dr F described the idea that academics should write books on ethics, books that are (ironically) unlikely to read by her colleagues:

Dr F: And I think that, I just imagine it would, you know, the doctors or the researchers within this fictional centre [studying primary care ethics] would write books on ethics and ...

AP: *Do people read books on ethics?*

Dr F: No, not people I know.

In the quotation below Dr Q bemoans the lack of specific guidance in the literature for his situation:

Dr Q: There's no book that says you can speak to a hostel care worker regarding this patient, I'm just sort of using my sort of clinical judgement or my common sense I suppose...

And yet if there were such a book Dr Q would seek other sources of advice and support in preference. He had made use of the 'five little books' of GMC guidance for his professional assessment. In practice, however reference to written material was not a personal choice.

Dr Q: I don't refer to a book, if that's what you mean, or a web site. No I never have.

Dr S, a GP trainer, educator and academic contributor to scholarship was also cynical about any direct connection between ethical scholarship and practice. A disinterest in or frustration with 'formal worked-out ethics' was commented upon both by academics and educators. In chapter 4 I discussed how successful contributions to academia might be inaccessible to the everyday practitioner, either because they used specialist jargon or because the precise argumentation required time to read and understand. This was time which many of the participants did not believe they possessed. This might contribute to or be in addition to a lack of interest in ethics scholarship. This was echoed by references to a lack of interest by trainees and non-academics participating -who used word like 'boring' (Dr F) or 'foreign language' (Dr Q).

Dr U, a senior freelance GP and former senior GP-educator reflected that principles of ethics and law are imparted by way of an instructional narrative. According to Dr U below there has to be an 'interesting' story of a 'practice' dilemma to engage the reader, followed by a solution which is provided by expert opinion.

Dr U: So a busy GP, or someone who has a matter of three or four minutes to think about an issue quickly and maybe reflect on it if it's relevant to their own practice, may absorb the interesting story of a practice dilemma, read what the medicolegal aspects are and what the expert patients say, reflect briefly on that and then store it away, unaware that they've absorbed

by osmosis some core ethical values. It's unfortunate that ethics has to go in this guise but it's the best way it will be communicated easily effectively and widely.

Dr U suggests that 'four minutes' is the time which might be allocated to thinking about such an article, which might typically be a single or double page with a large dramatic picture. The idea of osmosis as a way that 'good' values somehow go from a high to a low concentration according to the respective gradient is an old idea linked to ideas of etiquette and the apprenticeship model. His use of the word guise implies the idea that ethics is somehow camouflaged as professional behaviour or even as an entertaining narrative in a popular magazine. An entertaining narrative will capture and hold the attention of the reader, whether because it discusses or dramatises a situation of conflict, or is more of a cautionary tale. Drama and human interest is the delivery vehicle for camouflaged ethics.

Dr U also makes note of the medicolegal and professional aspects as essentially only non-covert part of what he referred to as 'sugar coated' ethics. Dr U's suggestion of an instructional narrative has echoes of Sokol's 'hour' for junior doctors (see above) where discussion of key problematic cases is used to illustrate key ethico-legal principles such as consent and confidentiality. It serves a similar function to the ethical code of practice, conveying knowledge and basic understanding. The inclusion of brief learning points in such a piece of writing demonstrates utility for the reader. The idea of 'sugar coating' ethics with relevance and narrative serves two vital functions –illustrating principles in action but also connecting them with human interest and making them less dry.

It appears that there are two kinds of reading described for the non-academic. Dr U described an overtly casuistic example of a case accompanied by a digest of the relevant points of law and etiquette – this might also be presented the other way round as an article highlighting the main principles of law or ethics illustrated with paradigm cases. This is akin to a simple and explicit parable, or a cautionary tale. Dr S, on the other hand, invites his trainees and students

to read a piece of literature and reflect on it. Dr S' use of literature still makes use of human drama, but the trainee or trainer has time to read and reflect, and possibly have a conversation with Dr S to discuss the reflections. There is still a utility – the reading is offered in response to a situation or learning need. The 'Quiver-full of arrows' approach appeared to be one which participants associated with a more protected environment such as the GPVTS or Trainers' Group, or a situation where the reader is willing to invest time to read and reflect. There may be a personal element of learning style here also, as Dr B illustrates below.

Dr B: I think it's hugely different for different GPs. And, as I say, I couldn't answer that question without again referring to sort of personal styles. To some extent, learning styles, but also, I think there are practicing styles. So my style is actually quite, I actually have to literally work things through and so, to some extent, my partner, who doesn't work things through and hasn't read half as much as I have, hasn't read – actually probably the honest truth is, he hasn't read a tenth as much as I have.

Discussions with participants about encountering ethics in printed literature illustrate a divide between enthusiast and non-enthusiasts. Utility and drama are the tools by which the latter group is engaged. The readings used for reflection by the ethical enthusiasts among the participants were of a different order.

The attitudes to ethics readings illustrate a gap between the theoretical literature and practice, and a gap between ethics and practice more generally. In particular they echo some of the problems generated by the influence of structures on curriculum – specialised reading can be unpalatable unless translated or signposted by someone with specialist skills. A useful analogy may be that some readings in ethics are 'available over the counter' for common conditions such as how to notice common threats to confidentiality, and others require prescription possibly with education on their best use.

Conclusion

Pedagogy in the ethics education of GPs contributes to the sum of lifelong learning. Education is frequently goal focussed, and this was the case among the participants. It is tasked with getting someone into the next phase of their professional narrative, or giving them skills for practice – I will discuss assessment of ethics in the next chapter. The ‘Four principles’ recur at every stage as a popular framework for understanding ethical issues, and they are possibly a marker to suggest that the more recently qualified UK graduates have received some sort of ethics education rather than picking up what society expects as they go along. The heterogeneity of recall by practitioners and the heterogeneity of experience in terms of time in the job, and country of qualification, may mean that - for ethics education to be assured - refresher are needed at regular intervals along a professional narrative. This is especially the case if, as Cribb and Bignold suggest, ethics education is an antidote to or immunisation against the more harmful aspects of hidden curricula (Cribb and Bignold, 1999).

In chapter 4 I noted the relatively disproportionate concentration of activity on undergraduate in comparison to postgraduate ethics curricula. In this chapter I have noted the forces that limit the availability and the accessibility of ethics education. The key difficulty for ethics education is clearly time – Campbell and Higgs described periodic necessity to refresh ethics as being like checking the tyre pressures on a car. Whilst it would be wrong to do this in heavy traffic, it is clearly something that needs doing to safeguard oneself against road traffic accidents (Campbell and Higgs, 1982a). Time needs to be set aside out of the busy day for ethics education, whether this is simply focussed on the starting concepts or reflection on more complex cases. Because there is limited space in curricula in for ethics in any distinct way, and integration may be synonymous with invisibility, multiple bites at this topic may be needed to counter the effect of ethics ‘missed’ because the classroom session occurs once a

training cycle, or is considered to be the most optional by students because it has the least marks attached to it in assessment.

Time, however, is not the only factor affecting accessibility. Education needs to engage with its target population. Reading as a pedagogic medium illustrates this – an effective reading needs to be simple enough to fit into the free time of the reader and be in language that the reader can understand. But it seems that this is not enough – it must engage interest either through drama, relevance or both. The reader must appreciate the importance of the ideas as well as their relevance if precious time, whether four minutes or an hour, are to be allocated to it.

Reading and experience of drama is perhaps the safest way to learn about ethics in that ‘someone else’ opens their practice and ideas up to scrutiny. However there is a kind of safety that also comes with formal educational settings – students and trainees are expected to get things wrong in a way that fully qualified GPs are not. That safety is mirrored in the connection between Balint groups and ethical issues

Living as an ethics educator and talking to those who teach and learn ethics in general practice brings home these key points: that ethics education is part of lifelong learning, that it may be easily missed, and that ethics education needs to engage with those who are educated on a practical and human level.

Chapter 6: Ethical encounters in evaluation

Introduction: Ethics as evaluation

In the previous two chapters I used the concepts of curriculum and pedagogy to organise ideas about ethics education in general practice (Bernstein, 1971). In this chapter and the next two I discuss the enactment of ethics education. This chapter is about the assessment of ethical knowledge, skills and attitudes – what Bernstein refers to as evaluation. In particular I explore those key evaluative encounters represented by formal assessment processes: selection for medical school, medical school examinations, and selection for general practice training, as well as qualifying as a GP and attaining Membership of the Royal College of General Practitioners (MRCGP).

However, aspects of evaluation in the stories of encounters with ethics do not end at qualification. General Practitioners are also formally evaluated when their professionalism is questioned in the adversarial setting of courts and GMC hearings. A more recent historical development is the formalisation of appraisal and revalidation. As with all other types of doctor in the UK, GPs now face a periodic assessment of their knowledge, skills and attitudes. I will consider whether this latter development can represent a limiting factor on the educational value of appraisals. Specifically I will argue that assessment brings with it a temptation to dwell on proficiency rather than explore uncertainty – especially as regards ethics.

Informal aspects of evaluation are not considered in this chapter as they relate more closely to the theme of formation: they have lower stakes, and play more of a role in learning than in quality assurance. For example in chapter 5 I talk about discussion groups as a form of pedagogy and in chapter 7 I discuss access to ethics support from colleagues or formal providers of such advice. Participants may have felt a certain ethical exposure when talking through difficult decisions with others, but the main purpose of such discussions appeared to be learning or support rather than formally verifying a GP's suitability to progress or continue in their career.

Evaluation of candidates for medical school

In the previous chapter (which described formative encounters with ethics) I observed that none of the participants mentioned ethics education in terms of preparation for medical school entry. Whilst the inclusion of a question about contentious issues in the public arena is not a new aspect of medical school interviews, the explicit inclusion of medical ethics as a topic for discussion at interview is a relatively new phenomenon. As an interviewer for a large medical school in 2011 and 2012 I was given ethical scenarios with which to test candidates' ability to recognise and discuss an ethical issue. In lieu of participant data I present quotations from two books which the younger participants (certainly the group of GP trainees) could have accessed to prepare for interviews. Richards and Stocktill (2001) outline in broad terms how the participants might have encountered ethics at a medical school interview.

With contentious issues such as ethics or politics, candidates will neither be criticised nor penalised for holding particular views but will be expected to be capable of explaining their case. Specific questions on subjects such as abortion, religion, or party politics are discouraged, but if they are likely to cause personal professional dilemmas, it is reasonable to have thought about

them and to be able to discuss how you would approach resolving such issues (Richards and Stocktill, 2001).

In another guide for prospective applicants published in the same period, Stein (2000) reiterates that the answers to an ethical question at interview are less important than the reasoning and evidence of prior reflection.

Your interviewers will probably be interested in your views on current medical issues, such as the funding of the National Health Service... euthanasia, or the pros and cons of the new genetics. You need to have some knowledge on these issues and to have formed your own opinions on them. There are no correct answers, but your remarks will help the interviewers to judge how much you have bothered to think about the burning political and ethical issues in UK medicine (Stein, 2000).

Stein lists resource allocation, euthanasia and issues around genetics as areas about which prospective students might expect to be quizzed at interview. All three areas were identified by participants as coming 'pre-labelled' as ethical. My own experience as an interviewer is that some medical schools now present candidates with scenarios that assess their appreciation of ethics in practice. Whether this will result in a pre-selected cohort of ethically-sensitive doctors and GPs remains to be seen.

Undergraduate examinations

When I co-authored a clinical finals preparation guide in 2006, I was aware (as a recent medical graduate) that medical ethics could be embedded within objective structured clinical examinations (OSCEs). Consequently that guide contained a chapter on ethics, albeit largely focussed on the hospital environment (Papanikitas et al., 2006). The King's College London

core medical curriculum, for example, also discussed ethical and social aspects of all the illness categories that it specified for learning in 2003.

Whilst participants did refer to undergraduate experiences in learning ethics, law and professionalism (including the relative lack of such experiences), none of them volunteered any stories about being tested on these topics as medical students. Ethics at medical school was more vividly recalled by participants in association with examination *preparation*.

Examinations represent the non-negotiable aspects, perhaps a ‘dress rehearsal’ for the non-negotiable aspects of ethics in professional examinations and problematic cases in later life. In the quotation below Dr O illustrates preparation for exams.

Dr O: In terms of preparing for the exam, I can, you know, I can remember sort of ethical frameworks of what was expected to do answer anything within, see if I can remember it - so the principles of beneficence, non-maleficence, equity and then there was a fourth one... what was the fourth one?!... – oh, ha, ha! There we go...

Dr O illustrates the perceived requirement to analyse cases using the four principles. As I discussed in the previous two chapters – the four principles approach is potentially offered as the way to think through ethics cases in materials aimed at every examination in a GP’s professional career. As I will show later in this chapter – it may sometimes be presented as if it is the only way to think through ethics.

Neither I nor the participants could recall any specific examples of multiple choice questions regarding ethics in final examinations. However many medical schools explicitly test medical ethics in combination with subjects like sociology and psychology. I was able to locate a page from the student handbook from Dr O’s medical school at approximately the time when he would have been there.

This course will be assessed in the [ethics, psychology and human sciences paper] as part of the case study, which will include questions that instruct students to discuss the moral issues that the case study raises. In particular students would be expected to show the ability to: 1. Distinguish between moral concepts and facts 2. Describe the moral dilemma(s) 3. Analyse the moral dilemma(s) 4. Provide a solution (or solutions) 5. Give argument and counter arguments for the solution(s)

Notably this description does not appear to privilege any method of analysis, and does not mention either principlism or GMC duties. I know that some of my own generation of GPs will have been assessed on their appreciation of ethics in practice by way of objective structured clinical examinations (OSCEs). The presence of ethics as something practical that is assessed in use rather than just in theory (as a skill to be deployed in the context of OSCEs) may give legitimacy to the subject as one that medical students (and subsequently GPs) consider worthy of some study.

Evaluation of candidates at entry into general practice training

At my own interview prior to entering GP training I was asked how I might respond if a patient asked me to end their life. I suspect that this may have been because ethics featured quite heavily at a theme in my own curriculum vitae and qualifications. Ethics was not an area that participants described in terms of evaluation at this stage of their careers. However, the trainees that participated would have had to do a 'professional dilemmas' paper as part of their selection for general practice. This is a 2 hour examination designed to assess the candidates understanding of appropriate behaviour for a doctor in difficult situations, testing competencies such as 'professional integrity' and 'empathy'. The examination format that my trainee participants would have experienced would have used multiple ranked answers

marked by computer with the answers set by a panel of expert GPs. Shortlisted candidates are then invited to a selection day, where they are observed in a patient simulation, complete a written prioritisation exercise and take part in a group discussion. (Papanikitas, 2011b). The computer-marked assessment evaluates candidate responses against correct answers, so successful candidates will have chosen answers corresponding closest to professional values. Situational judgement is a core component of selection for postgraduate training, and so there may be an invisible element of ethics assessment in both the professional dilemmas paper and prioritization exercise.

Ethics in the qualification to be a GP

The key difference between the older participants and the younger GPs (and GP trainees) lay in a fundamental difference in the way in which ethics are 'tested' in those examinations which defined them as a GP.

This difference lay partly in the kind of professional examinations the participant had completed. Until autumn 2007, there was a choice of two quite different routes for a doctor wanting to become a qualified GP. The easiest route was 'Summative Assessment', which usually involved completing a MCQ exam, an audit, a video of consultations, and a trainer's report (Riley, 2008). The other route was the old MRCGP exam, which involved two exam papers, an oral exam, and a more stringently marked video. After 2007, MRCGP became a compulsory qualification for all new GPs.

Summative Assessment

Just as Dr O recalled ethics in preparation for undergraduate examinations, Dr Q recalled a similar process in preparation for summative assessment. Ethics as he consciously encountered the subject was in the form of standards or rules as enshrined in the GMC's 'Duties of a doctor,' and how they might guide a response to a problematic issue. Consequently preparation for this assessment meant reading the GMCs guidance booklets on confidentiality and other issues.

Dr Q: And we all roughly knew the type of scenarios that they would give us, and apply the sort of ethical basis to that, you know like Dr Paul Parker (imaginary name) comes in drunk –that sort of thing- or you know he's taking drugs, how do you deal with that sort of case scenario? And basically you sort of use the four principles in how to deal with it.

For Dr Q, 'ethics,' as encountered in his qualification as a GP, involved choosing the right action in a constructed problematic scenario. The four principles approach was a tool to be applied in finding the right answer. The problems were predefined scenarios that had been labelled ethical. The answers could be model answers based on the duties of a doctor and discussed in terms of the four principles. It was unclear how the scenarios Dr Q mentioned might find their way into a multiple choice question unless there was a clear 'right answer.' This might be because the scenario was oriented towards a clear decision once all the principles and duties had been appropriately weighted or perhaps because the MCQ asked other factual questions, such as which principles or duties applied to particular parts of a case. Either way – scope for discussion and debate was very much limited.

Videotaped consultations

One of the ways in which the behaviour of a prospective GP at the end of their training was assessed was by submission of videotaped consultations. This is a feature of both summative assessment and the MRCGP, and it was identified by participants as possibly problematic. For

example, the candidate was in a position to edit the video so that it included only the consultations which showed his or her best light.

Dr G: ...the trainees under the old regime would record lots and lots of consultations, and cherry pick the 'best' of them, to submit for examinations...

In the use of video-recording of consultations, prospective GPs professionalism might be criticised if perceived to be inadequate.

A separate problem with video-recording consultations did not lie with the GP but with the patient. The consent process for recording consultations meant that (if followed correctly) the patient also had a power of veto over whether the consultation could be examined by strangers in a remote location. Dr G commented on this aspect of assessment.

Dr G: ...if you were to say to a patient, it's initially between the doctor and his supervisor or trainee or educational staff, but if it's sufficiently interesting or provocative, we might want to show it to somebody else. And if it's really juicy and somebody else sees it, we might go national. I mean they're going to say 'no' immediately aren't they? They can't be bothered with that. But I think if you know right at the outset that the intention is, at the outset, to reserve the right to take that to, to a very remote forum, I think you have to declare it.

Dr G picked up on the idea that a case that was problematic in some interesting or provocative way might be considered by the patient to be highly sensitive and confidential. As such there might be a problem with GPs' ability to demonstrate their skills in dealing with difficult cases involving ethical decision-making. Dr G felt that one way of working around this issue was consent by stages – and patients

taking part in videotapes consultations would usually be asked to give consent both before and after the consultation.

Dr G: But I think actually what usually happens in these studies, is that consent is sought in stages. For instance, in the exam context, which I'm familiar with, for instance, because ... they wouldn't know in advance that the one coming, about to be filmed, they wouldn't have decided whether it was going to be one that would be seen by examiners, because they didn't know whether it was good or not, in advance. So what was normally done is a kind of serial consent, which would say, first of all, 'Are you happy for it to be recorded for educational purposes? We may, I may want to submit it for examination purposes, in which case I'll contact you later to confirm that you're still happy about that.' And I think that works fine, because by that time, because obviously in advance the patient doesn't know where it's going to go. And people are perhaps a little bit cagey and uncertain. But afterwards, of course, most people realise that actually well there was nothing particularly scary about that, and perfectly happy for others to see it ... With the patient's right to say 'No, I don't mind you seeing it, but I don't want strangers seeing it.' Or actually what usually happens is, is that 'I'm happy for strangers that I don't know to see it, but I don't want people that I do know, or other people I know, to see it.' That usually happens.

In the above quotation Dr G suggests that patients may realise that their problem is not as stigmatizing as they had initially perceived, and thus will be happier for the consultation to be seen. This does not solve the problem of those consultations that are characterised by major emotional content, extreme disagreement, or a perceived stigma that is not dissipated.

Problems of positive bias and patient consent are less of an issue – video recording is now generally used for educational purposes only and for workplace-based assessment (WBA).

Because WBA is arguably formative (candidates demonstrate improvement rather than

excellence from the outset) there is less incentive on the part of the GP trainee to hide difficult consultations. As the trainer is usually a GP in the same practice, there is less potential concern about confidential patient encounters being viewed by strangers in a remote location. However, problems of participant bias and patient consent may be lingering issues where recorded observational research is conducted into the ethical behaviour of GPs, especially if those aspects of practice which are problematic are being sought. Consent to use of recordings in this circumstance may be withheld by either GP or patient based on their perceived exposure.

The 'Old' MRCGP

Several of my participants encountered ethics in the context of the old MRCGP examination. This involved writing essays, submitting videotapes of consultations and an oral examination. The idea behind the old MRCGP was that it represented a higher standard than summative assessment which existed in parallel as an exit examination for GP training. As such it was legitimate to ask candidates to engage with theory in the context of professional practice.

The subject of ethics was a perceived component of the old MRCGP. Dr G, a senior examiner for the MRCGP, described the ways that ethics was included in the examination. Many of the quotations from the examiners perspective come from Dr G as he was highly placed in the MRCGP for many years.

Dr G: ...under the former configuration of the exam, there was a strong ethical component running through that, both in terms of thinking about written questions and particularly in asking and assessing ethical dimensions in orals

Ethics in the old MRCGP was also perceived by participants who had been candidates. From the candidates' perspective, ethics appeared to be an explicit or an implicit component. Dr O recalled that he had to answer ethics questions, but could not recall anything specific about them. He could not recall any specific examples from either his oral or his written examinations. He did, however, recall that he had to reconcile some theoretical ideas with professional context.

Dr O: ...the trick was, answering the ethics questions was always as with any ethics question, to establish a framework to answer it in. And I answered it in terms of the individual patient and the practice as a whole apart from anything else. So the way you started thinking about indirectly principles of ethics in terms of equity and autonomy.

Dr O used the four principles of bioethics and related academic ideas of equity and autonomy to the professional context of the competing duties to the practice as a whole and the individual patient.

Dr E gave a slightly dissenting viewpoint to Dr O's, in suggesting that ethics was an implicit rather than an explicit component of the MRCGP.

Dr E: because if you'd have asked me, if when I took my membership, there was any emphasis on ethics at all – with a 'yes' or 'no' answer, I would have said, 'No.' And I don't recall any. But clearly there were in the... the sort of short answer questions... on a modified essay question or something, you saw something on one page and, you know, it would be that, you know, 'Mrs Brown's booked in to see you and when she comes in, they ask you whether her mother has been drinking,' and I mean clearly what one is looking for there is not just an understanding of the ethical principle, that breach of confidentiality is a serious issues of medical malpractice, and you need to be aware that that's the sort of scenario that you may do it. But it's more I think in, in – that is a key issue, but in addition in a membership exam, one is looking, not for someone to

make a cold brutal statement to the patient, but... seeking to understand their viewpoint and to be as helpful as they can. So I think the membership exam is seeking to or was then seeking to do more than one thing, and it certainly – I do not remember any exploration of whether one was able in terms of – you know, that scenario would not be followed by a question, at least in those days, I don't think, like, 'What are the ethical implications of this request?' I don't remember anything like that.

For Dr E the ethical components were implicit in the short essays. He gives the example of recognising confidentiality as the problematic concept and the desire for a nuanced view that can take into account conflicts and exceptions. Dr E was describing a written assessment as opposed to the oral examination, where an explicit discussion of ethical theory and principles might have taken place.

The MRCGP oral Examination

Participants who had done the old MRCGP had potentially faced a discussion of professional ethics in an oral examination. The notional advantage of an oral examination was that candidates could have their soundness of their knowledge and attitudes tested in a way that was somehow deeper than a written exercise.

Dr G: the element of professional discourse, where you can actually test them in conversation, the soundness of people's judgements and values, and whether they actually carry them through or not.

In participant accounts, the ethics component either involved either: a discussion about ethics and its application to practice or presented the candidate with an ethically problematic case for discussion. Dr G described one approach to ethics in the MRCGP oral examination:

Dr G: ...in the MRCGP exam... it was very common in all the situations to confront somebody – to have a 5 or 10 minute conversation about ethics – which would usually start in one of two ways, and different examiners had different styles of approach. One would be, you know, moving from general to the particular, would begin with, ‘Do you have an ethical framework, could you tell me what it is?’ ... And then, and then be confronted with something, with some situation that perhaps you know, they felt the principles were in conflict or it wasn’t immediately clear what was the right thing to do, think how they would apply.

Dr G expanded on how the examiner might evaluate candidates in terms of ethical expertise. He distinguished between poor, satisfactory, and advanced answers in the old MRCGP examination.

Dr G: So, for instance, a poor candidate might say, ‘I don’t know, I think I’ve heard of altruism...’ A medium level of answer might be, ‘Well there are a number of principles, four, for example, which are,’ and describe them and think how they might apply them in this particular case. Somebody at, with what I think most examiners would regard as a more sophisticated ethical awareness, would be able to say, ‘Those may be the principles, but they’re nothing, but in real life it’s much more complex than that, or they interrelate or they don’t deliver the answer, or it all depends on a number of other things.’ And so I think [that] the ethical dimension in practice is as multifaceted and as subtle and as hard to codify as all the other clinical things.

A satisfactory answer, according to Dr G, at least attempted to relate theory to practice. A more sophisticated answer might go further and critique the theory’s application in practice.

Dr G: I think the, the way most of my exam colleagues found or tried to differentiate somebody who was ethically sensitive or ethically developed from somebody who was not, was not to do

with whether they can articulate the four principles or any other number of principles, but whether they could actually see the inconsistencies that they implied.

The other approach used in the oral examination was to present the candidate with a deliberately controversial scenario. Dr G recounted his dismay at the abstractness with which candidates attempted to apply the four principles in scenarios that they could encounter in real life.

Dr G: And others, another style of approach, people would start with some particular clinical dilemma or consulting dilemma – ‘the patient says this, but you think that, how might you resolve it and can you infer any principles from that discussion?’ And there seemed to be such an awful lot of not-intentional humbug, but you listen to ...full-grown adults in their mid-twenties, coming out with statements like sort of, question, ‘A mother wants you go prescribe antibiotics for her child, but you don’t think it’s necessary, is there an ethical dimension to this?’ Answer – ‘Well there are four principles, blah, blah, blah and blah,’ and that’s not the way people think in real life, because people do not think in real life, this is an abstraction. And is not the actual means by which you resolve that moment’s uncertainty which confronts you in the consultation.

Not all the participants saw the complex cases in the manner experienced by Dr G. Dr E, for example, suggested the emphasis was on more on demonstrating how one might *handle* the scenario rather than a discussion of the ethical issues and content.

Dr E: Twelve year old Miranda coming in without her mother or even with her mother, for the pill, you know, all those kind of case scenarios, much beloved of the membership examination really ... it was more from the point of view of testing the candidate’s ability to handle a controversial consultation, rather than ...its ethical content, and identifying the ethical issues...

Dr E's different perception may reflect the lack of time in an oral examination, such that the discussion may include ethics or it might not. Not every oral examination was the same and not every examiner might have the same expertise.

Using the four principles appeared to be the preferred strategy for using a theoretical approach in oral examinations. I infer this for several reasons: The four principles approach was the only ethical framework to which participants referred in the context of any examination. Dr G repeatedly referred to candidates using the four principles. Moreover, an overdependence upon the framework is alluded to in the educational literature. Rhona Knight, a RCGP examiner, GP educator and member of the RCGP ethics committee published just such a comment (quoted below).

Evidence of this can be found in the oral exam of the MRCGP, which looks in part at ethical decision making. In a five-year period of examining, I recollect very few candidates who accessed any ethical theory other than Beauchamp and Childress' four-principle approach in their exploration of ethical dilemmas. Frankly, I find this concerning. Does what has been re-labelled by many as '*The Georgetown mantra*' really tick the box of 'ethical theory and the GP registrar'? (Knight, 2007)

Knight raises two concerns. Firstly candidates appeared in her experience to only favour one ethical framework. Secondly, implicit in the description of the framework as a 'mantra' is the idea that the concepts and or jargon are used uncritically and without depth by MRCGP candidates. Dr G illustrated this idea:

Dr G: And everybody would trot out the four principles and kind of look smug and wait for the next question, thinking that that was the answer.

In response to the question, “Do you have an ethical framework?” the four principles represent an ostensibly easy answer. It is an answer which has appeal to candidates who are desperate to give the right answer. However, it was not enough to simply articulate the principles, which begs the question of why candidates might respond to the question in this way. The principles generally loom large in the couple of pages devoted to ethics in MRCGP preparation materials (Stacey, 2008). Candidates preparing for the oral might rely on such revision texts or even on their notes from medical school. Examiners such as Dr G and Rhona Knight had the ability to appreciate and recognise an excellent answer from candidates, including the ability to recognise an excellent answer that might completely omit the four principles. However, it is not at all clear that this is something of which candidates would have been aware

iMAP

Prior to 2007, successfully completing the MRCGP examination was considered to be a badge of excellence (with a failure rate of about 25%). Older GPs who had done the ‘easier’ summative assessment are now able to obtain MRCGP by undergoing a process called membership by assessment of portfolio (iMAP). iMAP comprises two distinct assessment stages, the production of a satisfactory portfolio followed by an oral assessment, and grants full RCGP membership which is equivalent to that gained by the exam route. One of the participants, Dr Q, was in the process of completing the iMAP portfolio. Another participant, Dr M, was a GP appraiser and examiner –she had recently mentored colleagues through the iMAP process. The experiences of both are discussed below.

Dr Q: In those days the MRCGP was just an extra qualification if you wanted it. It wasn't compulsory whereas now it is compulsory. I am training to do my MRCGP by the iMAP route. I'm in the process of doing that as we speak.

Dr Q was commenting on the fact that MRCGP is now a mandatory qualification for all new GPs. The relevance of iMAP lies in the fact it confers a desirable credential. Whilst GPs who qualified by the summative assessment route are not obliged to take the MRCGP, it is also legitimate for employers to require MRCGP as a requirement in GPs. Whilst failure does not prevent a GP from remaining in practice, iMAP is an expensive and time consuming examination, and success allows a GP to use the post-nominal MRCGP, something all new GPs in the UK have by virtue of qualifying. The iMAP portfolio is essentially a proforma document that is completed by the candidate.

Ethics, law and professionalism are explored as an explicit component of the evaluation process.

Dr Q: One of the components is... "Discuss an ethical dilemma that you came across. And how did you deal with it?" In my day to day practice I've been trying to find a scenario that would be appropriate, or that they would accept. It is part of the iMAP process.

Official tips on how to fill the ethical principles section are as follows:

Criterion 14: Ethical Principles (RCGP, 2012)

- Needs to be an ethical discussion applied to a clinical problem
- The clinical problem should be clear (though the final outcome may not be)
- The discussion needs to show how all sides of the problem were considered within an ethical framework
- Read about and refer to an ethical framework
- Read and refer to GMC advice

Whilst the 5th point refers to GMC advice, there is strong emphasis on use of an ethical framework. The overriding perception I obtained, by looking at the guidance materials which Dr Q would have had access to, was that (if he read them) he was strongly encouraged to refer to GMC guidance and use 4 principles as the ethical framework for analysis.

The candidate is also expected to state what guidance has been used to reflect on the situation. The handbook guidance favours the four principles of bioethics as the ethical framework used, as illustrated by this quotation from the 2012 iMAP handbook:

Guidance: **You will need to show familiarity with** the four medical ethical principles. **You may find it useful** to use the four ethical principles of Autonomy ('self-rule'), Beneficence (to do good), Non-maleficence (to do no harm) and Justice (to act fairly) to structure your submission. **You can use an equivalent framework but this should be a recognised one and needs to be referenced (RCGP, 2012).**

I have deliberately highlighted two sections of the above quotation as at first glance the guidance in the handbook demands familiarity with the four principles. The below sample entry from the RCGP website illustrates this. The third highlighted part of the quotation attributes validity to an ethical framework based on its recognition by academia – a minimum criterion being publication. Implicit is the idea of the publication being from a peer-reviewed academic source.

The RCGP website contains a sample iMAP portfolio entry for ethical principles (RCGP, 2010). Perhaps a satisfactory answer has to be one which may be found in a peer reviewed journal such as the example below.

Sample entry: The ethical framework I used was based on the 'four principles plus scope' approach described by J Gillon¹⁵ in the BMJ [referenced]. The four principles are respect for autonomy, beneficence, non-maleficence and justice. The scope is how these four principles are applied... (RCGP, 2010)

The sample uses the four principles, and links them to a reference in the British Medical Journal. This does not give any idea of scope to candidates, but arguably confirms that they should stick with the four principles, because they are what the medical profession uses as an ethical framework.

The RCGP example uses a sample case involving an elderly residential home occupant whose health has deteriorated rapidly and is refusing to be admitted to hospital. The proforma asks the candidate to give a brief description of the clinical situation. In the quotation below the sample candidate also includes the dilemma within that description.

Sample entry: My dilemma was that I was not sure that he was at the end stage of life, and therefore if he had intravenous antibiotics and fluids his condition might improve. Also, my concern was that in commencing a syringe driver I would be hastening his demise ... (RCGP, 2010)

¹⁵ It is R Gillon – the typographical error is in the guidance

The candidate is also expected to discuss how the ethical framework was used to reach a decision. As an example I include a quotation of how justice might apply to the case from the RCGP sample entry.

Sample entry: Justice – is the moral obligation to act on the basis of fair adjudication between competing claims. Gillon divides justice into three categories, distributive justice (fair distribution of scarce resources); rights based justice (respect for people's rights) and legal justice (respect for morally acceptable laws).

I think this principle was not as important in this case, as the balance between beneficence and non-maleficence and the respect for the patient's autonomy. However, sending the patient to hospital would have involved much more cost to the health service. It could be argued from a distributive justice point of view that this scarce resource would be better spent on a patient who is more likely to recover and be able to lead a better quality of life and therefore possibly contribute more to society. Having said that, had the patient expressed a wish for more intensive treatment then I would have respected his decision (RCGP, 2010).

The proforma also invites the candidate to state the outcome of the case and to write a final reflection on how the case was handled.

Having had previous conversations with Dr M about iMAP, I asked her about the RCGP guidance (see above). She suggested that there might be some intrinsic limitations to iMAP guidance, that some limitations might be expressed by the candidate, but also that also that examiners might also potentially have a limited scope in terms of marking the ethics component.

Dr M: Yeah well I certainly would not rigidly just apply that. It would seem a rather narrow way of doing it ... There are some moral issues, there may for example be the moral issues of power imbalance, power -for example- does not necessarily come into the four principles. It may do in coerced autonomy or something but again it could be quite subtle, quite difficult to identify if you're not thinking about it.

Dr M raised two issues with use of the four principles in the iMAP assessment. In a way that was reminiscent of Dr G's comments regarding the old MRCGP oral examination, she describes candidates 'trotting out' the four principles, but not really knowing how to apply them.

Dr M: ...before you even begin is there's got to be awareness. You've got to be able to identify that 'a' there is an ethical issue which for some people, they don't see it. So if they don't even see it you don't even, you can't even begin. Then they've got to identify what are the moral issues, which again may escape them... I would first have to know did they identify the problem, did they identify the issues, and then how did they start, you know, working out a way through, because you know you can get people to trot out the four principles and then, and then they look at the problem and it hasn't. -how do they weight, how should one thing, why would one think be more important than another.

In a subsequent (unrecorded) discussion about my findings¹⁶, Dr M suggested that the simplicity and prescriptiveness of the manner in which the four principles had been adopted might relate to the examiners not being 'well versed' (her phrase) in ethics. She cited the example of an iMAP candidate whom she had been mentoring who was told that the submitted portfolio entry did not relate sufficiently to ethics. Dr M described the case as presenting a very challenging ethical dilemma that in her opinion *was* worthy of inclusion as an iMAP entry. An alternative explanation for her mentee's scenario being labelled, 'Not ethical enough,' might have been that the examiner did not perceive an ethical issue because the answer appeared (rightly or wrongly) clear. Dr M was not able to share the details of the

¹⁶ Unrecorded discussion 16/7/12

scenario with me,

iMAP is particularly interesting because it requires that a candidate uses a referenced ethical framework to reflect on a real clinical case from their recent practice. This is something that neither old nor new MRCGP examinations have strictly insisted upon. Dr Q was the only participant in the study who was undertaking iMAP at the time of interview. He shared two potential examples of cases which he might reflect on. Both cases concerned issues of who should be able to access parts of a patient's healthcare record. Whilst I have written elsewhere in this thesis the idea that confidentiality is a perennial concern for clinicians (Papanikitas, 2011a), I have also suggested that confidentiality is easier to discuss as a real issue involving cases. This is perhaps at least in part because deliberately hastening someone's death (see the RCGP sample entry above) is a more serious issue to reveal to a stranger than whether to discuss breaching confidentiality.

The new MRCGP

The Royal College of General Practice Examination which is now a compulsory examination for all new GPs can test ethical knowledge skills and attitudes through: a Workplace-based assessment (WBA), a clinical skills assessment (CSA), applied knowledge test (AKT), and the requirement to submit a complete electronic portfolio of learning at the end of the training years.

Applied theory and practical skills are evaluated by a trainer in the workplace, and independently quality assured in the two examinations: the AKT and the CSA. The AKT is a computer-marked timed examination aimed at assessment of relevant knowledge and reasoning. The CSA is a simulated general practice surgery where role players are used to assess candidates' knowledge and consultation skills. The qualification – a combination of

workplace-based assessment and examinations remains a statement of competence, of being 'finished.'

Workplace-based assessment of ethics in general practice and the eportfolio

Newer GPs have the task of incorporating ethics and professional behaviour that is assessed in the workplace into reflective portfolios. The web-based log in which they are required to record their reflection and learning (Dr F referred to this) is called the e-portfolio. It also contains the results of examinations and workplace-based assessments. It is submitted at completion of training in order to obtain the MRCGP qualification which is now the requirement for entry on the general practice register. The diary entries contribute as evidence of learning towards the above learning outcomes. Gillies argues that, by analyzing issues using an ethical framework, trainees demonstrate learning outcomes from the RCGP curriculum. Until 2012, this would have been linked to Statement 3.3.

Dr F was aware of the RCGP statement on ethics and values-based medicine, in so far that this curriculum statement was embedded in a tool used for workplace-based assessment, the e-portfolio. However, she could not recall any specific examples in her own e-portfolio.

AP: Okay. How would you go about sort of tackling that part of your portfolio?

DR F: Well when I, the way I sort of include it is, when I see patients where there's an ethical dilemma, then I write them up as clinical encounters and I'll tick the ethics box. So that's probably to date that's what I've done. I'm trying to think of any other examples. If I read something about ethics, that was relevant to general practice, then I would mention – I'm not sure if I have done. You know, I'm not particular great with my e-portfolio. I find it a bit

frustrating. I don't, you know, I think I do a lot of learning and I don't document every single piece of it...

The idea of ethics as a “box to be ticked”, which Dr F described, implies that the goal of incorporating ethics for the trainee was primarily to submit a complete portfolio and thereby to qualify as a GP. It coincided with comments about training sessions on ethics such as Dr D recalling that the VTS course organisers, ‘Just had to touch on [ethics]’. Even though for all the participants who were undertaking the new MRCGP there was an ethics box of sorts to be ticked in the e-portfolio, this was one of many items they needed to demonstrate that they had ‘covered’ in some way. This is potentially the same kind of negotiation for time and attention that ethics is subjected to in the undergraduate setting. The key difference is that the amount of time for learning and reflection is vastly reduced by comparison

The ability to select consultations upon which to reflect in the e-portfolio requires ethical awareness. Otherwise the trainee may rely solely on pre-identified types of case such as requests for abortion or for assisted suicide or only cases that fit with a paradigm such as a consultation with the driver who has uncontrolled seizures. There is a vast variety of cases that may be written up in the e-portfolio.. Riley et al acknowledge this in the RCGP curriculum guide:

Less obvious issues crop up all the time in day-to-day practice. For example, considering to what extent to twist someone's arm when attempting to persuade them to stop engaging in what you believe to be a harmful activity, such as smoking, involves a judgement based on the conflicting principles of autonomy and beneficence (Riley et al., 2007b).

An alternative to reflecting on consultations is reflecting on readings. The following quotation from InnovAIT, the RCGP journal for GP trainees, outlines this approach and echoes the point about the potential diversity in what may be reflected upon as ‘ethical’.

It can be difficult to get around to writing e-Portfolio entries on ethical issues, and usually entries are triggered by 'headline' issues such as assisted wills or treatment rationing. Andrew Papanikitas and Peter Toon wrote a brief article in the November edition of the British Journal of General Practice that focussed on mundane events in everyday general practice. The e-portfolio entries do not need to be long. If you read this and wrote down some thoughts about its relevance to your own practice, you would have a high-quality e-Portfolio entry that might help fill one of your curriculum gaps (Papanikitas and Toon, 2010, Etherington and Van Hecke, 2011).

GP trainees are formally appraised by workplace based assessment using two assessment tools: case-based discussion –CBD- (where a trainee presents a clinical case and discusses aspects of it with the educational supervisor) and the consultation observation tool –COT- (a formal method of assessing an observed consultation or video of a consultation between a trainee and patient). Knowledge and understanding of ethics as well as the trainee's own values and attitudes in practice may be assessed in CBDs under the heading, 'maintaining an ethical approach to practice'. Trainees are guided to complete a minimum number of CBDs (and COTs), including some which demonstrate ethical issues, ethical reasoning and ethico-legal knowledge (Gillies, 2009).

GP trainees in primary care usually undertake the case-based discussion with their own GP-trainer, who enters the record of the discussion, along with learning outcomes demonstrated and further learning goals into the trainee's e-portfolio. Critically the trainer may identify issues which the trainee may have overlooked or challenge the reasoning and reproduce the necessary discussion and argument. Whilst none of the participants discussed undergoing a CBD as a trainee, Dr B, a trainer gave an impression of how ethics might be raised in a CBD.

AP: ...when you're sort of encouraging sort of reflection, how might you go about that, how might you draw out the, the sort of the ethical content of that?

Dr B: In different ways. I think one main task, non obvious questions. So, for example, if a mother is there with a child with a rash, fine, I may well ask about the rash or I might decide the rash is boring. I'm talking now say about looking at a video, because obviously if it was a joint surgery, you'd just have to attend to the patient. But if it was a joint surgery after the patient had gone, but in my own practice, more likely looking at videos, I might ask the registrar - if I believed the registrar was basically competent about that rash, I might think that was a very boring thing to talk about, and ask the registrar to describe to me the way the mother interacted with the child. If the registrar wasn't sure about that, then I'd suggest we'd look at the video for a second time, with the sound off, which is often a very good way of getting registrars to latch in to communication issues, if you can, if you can cross out the content of what is said. Or I might ask the registrar what he'd learnt. Say if the registrar had seen that patient on a number of times, or another family member a few times, I might ask what they knew about the family, what other issues were going on, why the mother brought the child, etc. etc.. So those sort of issues. So at the moment we're dealing mainly with sort of family, psychosocial issues, and all of that to me, you could either say borders on the ethical or has an ethical component to it.

An example such as that which Dr B outlines above might well be included by the trainee as a CBD in the e-portfolio. Whilst it contributes to the in-course it is also a case of assessment being combined with learning. However it relies on the trainer having the expertise and the willingness to take the discussion in the direction of ethics.

None of the participants discussed ethics in connection with the COT. Though ethics is not formally considered in the COT, it is expected that ethical practice should apply across all GP work (Slowther et al., 2006b, Riley et al., 2007b). Some COTs will provide opportunities to

demonstrate ethical insights during reflection and feedback on the case being assessed (Gillies, 2009). However the kinds of ethical issues that might arise in a COT *were* discussed in connection with the new clinical examination, which is designed to simulate consultations, and I discuss this below.

Multi-source feedback (MSF) and patient satisfaction questionnaires are also used to expose professional 'blind spots' both for trainees pre-qualification and fully qualified appraisees. The feedback itself may provide a learning opportunity (Deighan, 2008). None of the participants discussed the MSF, in any context.

The MRCGP workplace based assessment presents an opportunity for trainers to explore ethical knowledge, skills and attitudes and trainees in a manner that is mandated by the fact that it 'counts' towards qualification. As with any administrative process, there is a risk that the task becomes an ends rather than a means. Rather than having an opportunity to reflect on the ethical content of ordinary and extraordinary practice, WPA may come to represent a laborious box-ticking exercise. This may possibly come with an undesirable side effect that ethical issues are conceived as somehow separate from social and clinical issues, and trainees seek a set number of prescribed dilemmas rather than document their better understanding of ethics in daily practice.

Ethics and the Applied Knowledge Test

Trainers among the participants also remarked on the preoccupation with anything that might be tested in an exam. Dr R, a GP Trainer refers to this in the comment below.

AP: I was just going to ask, just tangential to that, what kinds of issues over the years would you say that trainees have flagged up as of interest to them in general practice?

Dr R: To be honest, on the whole, they flag up the ones that come up in the exams. So they usually flag up the sort of the, the medico-legal ones, because those are the easiest ones – I mean certainly now, because those are the easiest ones that, to put, to do, to put in the AKT [Applied knowledge test]. So they want to know about confidentiality. They tend to see it in rather a black and white sort of, you know, “We need to know what the laws are.” And that’s all right, because after all, the point about the law is to be the bottom line.

Whilst I did not have access to the RCGP question bank for the AKT Dr R’s comment is reflected in revision preparation materials. The RSM Press ‘New MRCGP in a box’ (Punukollu, 2007) set of revision cards includes a card on the Data Protection Act 1998, and 2 cards on key elements of public health law, one on mental health legislation, but nothing on professional or philosophical ethics. If computer marked multiple matching questions require a prescribed set of answers to a prescribed set of questions, it seems natural to seek out those questions, and having found them to seek those answers.

The Clinical Skills Assessment (CSA)

Whilst the examination might delegate a peer-to-peer discussion of ethics and values to course work, the enactment of professional values is tested in the CSA. In the new qualifying examination for UK GPs, the oral examination has been removed and a structured clinical examination -the CSA- added. The CSA assesses, amongst other things, professional attitudes, defined as, ‘Practicing ethically with respect to equality and diversity in line with accepted codes of professional conduct.’ Riley et al give the following examples of ethical issues which may occur in the CSA: abortion, chaperones, confidentiality, euthanasia, rationing of healthcare and whistle-blowing (Riley et al., 2007b). It also assesses the ‘domain’ of

interpersonal skills, which covers communication skills and developing a shared approach to managing problems. The CSA assesses ethical and legal knowledge and professional attitudes in context, integrated with consultation skills and clinical knowledge. Unlike the process by which candidates went looking for ethical cases for iMAP and the MRCGP coursework the CSA requires the candidate to recognise the ethical aspects and act appropriately. Being 'ethical' is demonstrated through appropriate practice.

Dr F, a trainee about to undergo the CSA, gave examples of the types of scenario which might test the ethics of an MRCGP candidate. She had been on at least one preparation course run by the RCGP. I asked her how she imagined that ideas of good, bad, right, wrong, professional, unprofessional, legal or illegal would be tested in the CSA examination.

Dr F: Yes, so another example would be a patient who wants a particular tablet and it's just completely unwarranted. Or wants referral and there's no need. A patient who – a telephone consultation and the patient over the phone wants you to do something and actually you need to see them and they don't want to come down, or they phone from far away. A patient who's on methadone, or a patient who's taking lots of benzodiazepines¹⁷ and they want a prescription and there's some dodgy story like they've lost them or they've lost their piece of prescription.

What is immediately striking about the scenarios described above by Dr F is that they do not involve discussions about abortion, euthanasia or confidentiality. Resource allocation is possibly the only big pre-labelled ethical issue here. All Dr F's examples involve some sort of doctor-patient conflict – the patient wants something which the doctor should not provide. Implicit in refusing to give an unwarranted treatment, or making an unnecessary referral there is often a question about resource allocation and opportunity costs. Implicit in discussions of

¹⁷ An anxiolytic medication which is also used for sedation and a common drug of abuse

telephone management and prescribing controlled drugs are considerations of doing good and avoiding harm set against patient convenience.

Dr F went on to describe a situation in more detail in which a fellow trainee failed (in a simulated setting) to demonstrate a recognition of a conflict of rules and principles which required resolution. In the example below, a trainee did not attempt to resolve a problem because he had not recognised the existence of the problem in the first place.

Dr F: ...some people I think, basic things need to be explained. Like when I went on the CSA [clinical skills assessment] original course, and there was a guy on the course – the scenario was, it was hilarious, the scenario was that there's a methadone user and she says that her prescription got stolen from her, and it's a really flaky story. And he gave it to her. So either he was really nervous, people do whacky things when they're nervous, or he just didn't understand that, you know, you can't just give away methadone especially when there's a slightly dodgy story, he just didn't realise that.

The scenario in question was being used to test the ability of a candidate to balance a patient's wishes against the requirement to follow practice regulations, or to balance them against the risk of harm to the patient or others in the context of general practice. It is a simulation of a plausibly common scenario encountered, particularly in urban general practice. The candidate must recognise that there is a conflict in a scenario which has been deliberately constructed to be problematic and resolve it in an appropriate manner.

I asked Dr F what a model approach might be to that particular case.

Dr F: You need to try and ascertain the correct information. You need to explain to the patient that you can't, just like that, you know, give them a prescription, because – and you explain to them why, and negotiate a more appropriate way of dealing with it. You know, for example, that okay from now on you need to maybe – the solution may be to go to the local, a particular

pharmacy and get the methadone from them and you would get it on a weekly basis or daily basis. And alter things to make them sort of, to try and avoid that situation from happening again. And manage things, bearing in mind that this patient has come to see you because you're not going to take it at face value, they do want to – they don't want to be starting using heroin again.

Dr F identified this scenario with ethics in hindsight. Her model answer approach embeds ethical concepts in practice. Without asking Dr F to describe her thinking, however, it would be difficult to know if she understood *why* she might do things in a particular way. The disadvantage of the CSA is that it assesses actions rather than thoughts. Dr G reflected on the loss of the ability to examine the reasoning of MRCGP candidates.

Dr G: in the present configuration of the [MRCGP] exam, which is a huge advance in some ways, but what has been lost is the element of professional discourse, where you can actually test them in conversation, the soundness of people's judgements and values, and whether they actually carry them through or not. That's missing.

The CSA also assesses the domain of interpersonal skills, which covers communication skills and developing a shared approach to managing problems. Some candidates therefore might share their thinking with their assessors by thinking aloud and sharing their decision-making with the patient. An important point here is that all ethics, communication skills and medical knowledge are integrated; it is not possible to practise ethically without having both a high standard of clinical knowledge and the communication skills to understand the patient's experience of the illness (Gillies, 2009).

Evaluation in Practice

Appraisal and Revalidation

A relatively recent development in medicine has been the explicit linkage of appraisal to assessment – as well as being a confidential assessment of strengths and weaknesses conducted with the purpose of identifying patients' unmet needs and doctors' education needs (PUNS and DENS), the appraisal is now a component of the 5 yearly reaccreditation of doctors in the UK. The two issues that this generated in terms of ethics in appraisal were the recurring issues of time and safety. Participants did not discuss any changes to appraisals as a result of revalidation with any clarity.

Dr U: I'm not aware of anything massively new, apart from the colleges pushing forward with re-accreditation and that's about the toolkits, I guess and revalidation.

Dr N argued that ethics as a theme should be a compulsory part of examinations and also that it should be a compulsory element of appraisal. As far as she was concerned unless it was a specified element of such evaluations some GPs would not even be aware of it, much less engage with the topic. This was a view which was echoed by other participants. Professor Y articulated the idea that busy doctors will make time for the things which are compulsory.

Prof Y: When you're actually in practice, you know, working from 7 until 8 or 8 until 7 or whatever, you don't have time to do it. Not to reflect meaningfully, unless you're going to do it for your portfolio.

Many of the educational activities which are accredited to count as continuing professional development time towards appraisal for GPs include courses in medical ethics and meetings on topics in medical ethics. These must obtain approval from one of the royal colleges, universities or learned societies to count in this way. Dr E added that some of the resources are accordingly geared for busy GPs

Dr E: ...even at my busiest times, as part of appraisal and eventually revalidation, I mean there are numerous training modules online and so on.

Ethics can be revisited in annual appraisal and revalidation which have specific entries for probity, professionalism, and ethics. Roger Neighbour, a former RCGP President, reflects on the counter-intuitive nature of an appraisal process that invites a kind of confession which general practitioners might fear making for the sake of their professional status.

Roger Neighbour: Cynic that I am, I'm usually more alert to the muddle and palm-greasing that spawn the latest good idea than I am to the lofty ideals its advocates claim for it... But with appraisal it's been different... I am, after all passionately convinced that guided introspection is the best driver of adult learning... But here's an interesting question, slipped unobtrusively into Form 3, page 6: 'What safeguards are in place to ensure propriety in your... use of your professional position?' In other words, are you Harold Shipman? No I'm bloody not. And if I were, what would I put?' Curses, you've got me bang to rights, I'm a murdering psychopath'

(Neighbour, 2005b)

Neighbour's comment ties in with professional anxiety over exposing ethical inadequacy. I have written elsewhere that such professional fear might paradoxically inhibit people from seeking ethical advice (Papanikitas, 2011a). Opening up behaviour to ethical scrutiny can raise the fear that behaviour will be deemed by peers to be deficient. This has two key adverse outcomes: firstly discussion will only involve what the narrator thinks he should do (rather than what he does), or secondly that discussion will fail to take place at all for fear of reprisals

rather than remediation. For one's decisions to be deemed unethical is similar to them being deemed un-professional – both place the practitioner out in the cold if the decisions are deemed unworthy. The phenomenon of ethicality refers to the interest a profession has in policing itself so as to maintain control over its work (Freidson, 1988). The fear is that one will fall foul of ethicality. In a profession's desire to hit certain standards to maintain status, poorly performing doctors will be sacrificed rather than helped to achieve the same standards. Or in being seen to receive assistance a GP loses individual status. This set of concerns can be summarised in the following way:

1. The rules are unclear
2. If I ask about the rules, I will be seen to be deficient in my knowledge by my peers
3. If I am seen to break the rules, my peers and society will judge me harshly
4. If I think I am breaking the rules, I reveal this at risk to my professional status

Fitness to practice

Investigation by a professional standards organisation (such as the General Medical Council) is another example of such concern over a high stakes evaluation. Another example might be being sued for negligence. The stakes are high because censure by the GMC or successful prosecution might result in loss of employment or prevention from further employment. Disciplinary or legal proceedings in the event of alleged misconduct are final assessment of right or wrong-doing. GPs are subject to the same laws as anyone else and the same legal and professional duties as all other doctors.

None of the participants in this study admitted to being or having ever been subject to either a lawsuit or investigation by the GMC.¹⁸ A surrogate experience described by participants was the occasion to seek advice from a medical indemnity organisation. Like any other type of doctor, GPs contact an indemnity organisation to avoid litigation or anticipating or following a complaint. The particular circumstance where the two would overlap is where someone goes to their indemnifier as a result of being investigated by the GMC or sued for negligence.

Participants displayed a certain embarrassment at needing to seek medicolegal advice. Dr N described feeling initially embarrassed the first time she used her provider of medical indemnity. Dr O jokingly suggested that his confession that he made a lot of use of his medical indemnifier made him sound like 'a shocking doctor'.

By contrast, other participants were keen to tell me if they rarely needed to talk to an indemnifier, as with this quotation from Dr G.

Dr G: No I don't think I've actually, touch wood, too late to touch wood after my career is finished, but I managed to get through it with nothing terribly serious in the way of either ethical issues or complaints.

This was echoed by Dr B, who proudly stated that he had only telephoned his indemnifier four or five times in thirty-one years of practice, He went on to give me an example where he had been sure of the right thing to do and sure that it was also legal defensible. In another example Dr Q was at pains to state that on the one occasion that he telephoned his indemnity organisation it was over a 'salary issue' rather an 'ethical issue'.

Dr E raised a concern that unethical doctors might still satisfy a professional body that they had followed guidelines. He cited the example of refusing to disclose details to a patients

¹⁸ One potential participant who had been briefly suspended by the GMC over an ethical issue, subsequently declined to participate.

relative or carer in circumstances where disclosure might be the morally correct course of action or a compromise might be better. He was concerned that the GMC and MPS might be approving of such a doctor on the basis that they had kept confidentiality.

In Chapter 3, I commented that two GPs after expressing an initial interest chose not to participate and one of them was good enough to volunteer a reason why. He handed me a printout from the GP magazine *Pulse* (Iaccobucci, 2010). The article concerned twenty four GPs who were facing censure out of two hundred and forty-five volunteering for pilot trials of a new type of professional appraisal. The article also commented that over 3,000 doctors were invited to take part in the pilots - taking place across 10 different locations - and around 650 doctors had volunteered. The headline warned of a witch-hunt (using those words). The article mainly concerned GPs with other interests who were deemed not to have spent enough time in general practice to be considered fit to practice and had little to do with discussion of ethics specifically. More generally, it reflects the anxiety that external scrutiny may have adverse professional outcomes for the doctor being evaluated. The article has additional relevance in that it was associated with my study in the mind of a potential participant.

Professor A, an educator and commissioner of general practice education at a national level expressed a similar disquiet:

Prof A: The big difference is, I'm concerned that the more you regulate and legislate and bureaucratise, you create a climate of fear, you create a climate of uncertainty, a climate of insecurity, it, the regulation, which is supposed to protect, really, I think leads to a cover-up kind of activity. People do less outside what's in the box is defined, because they're afraid to do so. And that's more about the young... I mean they should have fundamental principles, but we're not going to be able to define everything for them if they are afraid of going out of the box... then we're going to have a defensive kind of culture.

Professor A's comments link back to the students' and trainees' preoccupation with knowing the right thing to say in an examination, and preference for definite rather than indeterminate answers as evidenced by the desire to discuss law and professional guideline rather than ethics of a more analytical nature.

Conclusion: Evaluation is a game with increasing stakes

Time and safety recur as themes in this chapter. The pressure on time in a crowded curriculum means that the presence of ethics in formal assessments is what makes it visible and explicit rather than part of an invisible subculture. The presence of ethics in assessments mandates reading, discussion and reflection for GPs in the various stages of their careers. In this study I have not talked to sixth formers, medical students or prospective candidates for GP training. Instead, the inferences I make are taken from the professional narratives of GPs, GP-educators and GP-academics, which are in turn offered from personal narratives and observations. Those narratives and observations tell a story of increasingly high professional and personal stakes at each stage of a doctor's career as he or she comes under external ethical scrutiny. However this is partly coloured by hindsight – one can imagine that for a sixth-former, demonstrating aptitude for medical school is a most important evaluation, as for a medical student, is demonstrating the competence to be a safe and effective junior doctor. Nevertheless, the narratives of evaluative encounters with ethics illustrate increasing stakes and decreasing safety for the professional in the discussion of ethical issues as education gives way to practice.

Assessed coursework for GP trainees represents an opportunity to evolve beyond narrow approaches to ethics that might be favoured by a higher stakes oral examination – such as the four principles and a need to give the “right answer” as perceived by both candidates and examiners of the old MRCGP. The focus on pre-labelled issues and favoured answers is still present, however, and this may be exacerbated by the delegation of case-based discussion to trainers, many of whom may not have advanced skills in terms of ethics, law and professionalism that RCGP oral examiners might. The danger of focussing on set approaches to ethics too rigidly is that legitimate approaches and issues presented by GPs for academic

evaluation may be unfairly discriminated against. The stakes involved may act simultaneously as a driver for learning and, could paradoxically constrain deeper understanding. This is because those who are assessed may be more eager to give their examiners the answer that they think the examiners want to hear than to critique or debate it.

The non-negotiable nature of making ethics an implicit or explicit feature of assessments and external scrutiny put ethical sensitivity and basic skills in moral reasoning on the GP's educational agenda. However, the other forces acting on GPs in their professional narratives need to be accounted for. The fear of criticism and censure arguably may prevent GPs from sharing the learning which they have gained from failures, and possibly even admitting to them in the first place. It may also create a reluctance to open up their ideas about good and bad, right and wrong, professional and un-professional, because such ideas define the boundaries of practice. Ultimately discussions about practice that is ethically uncertain may determine who remains in and who is ejected from the profession.

Chapter 7: Encounters with Ethics in practice

Introduction

In the preceding three chapters I have considered curricular aspects of ethics education, pedagogic aspects of ethics education and evaluation aspects of educational assessments. I have examined (Bernstein, 1971). The emphasis on ethics education as a classroom rather than a clinical activity was a phenomenon that participants either identified with (themselves) or identified in others.

Both undergraduate and postgraduate curricula are crowded, and therefore the identification of any subject as being optional risks its omission by learners. Consequently, the presence of ethics as a subject for assessment in undergraduate and postgraduate examinations flags the subject to learners as one requiring some study. However those assessments either limited learning to a core curriculum by emphasising particular sub-topics and approaches, or de-prioritised the topic by awarding it fewer marks in the sum needed achieve whatever qualification it might be linked with. Whilst lip service is paid to the notion that an understanding of relevant ethical theory is core and fundamental, for non-enthusiasts there seemed to be a kind of negotiation over what amount of engagement with scholarship was necessary to pass exams and avoid being criticised in practice. This all leads to the question of whether what is learned and examined in educational settings adequately reflects the knowledge skills and attitudes that are required for practice. Therefore, in this chapter and

the next I consider a particular aspect of evaluation (Bernstein, 1971) that differs from the formal academic examination setting, namely ethics education as enacted in ethical practice.

The non-negotiable necessity of practicing in a way which is consciously ethical is widely reflected in professional literature, such as the quotation below from a professional development handbook aimed at fully-qualified general practitioners.

Being a good GP is an odd compound of broad knowledge, multiple skills, deep stickability and a touch of showbiz: but even just to get by we need some understanding of how to make moral judgements (While and Attwood, 2000).

In this chapter I describe the identification of ethics in practice and the general approaches to ethical issues. I have looked at situations outside of the protected educational environments that are represented by the reading room, lecture, classroom, or directly supervised consultation. This chapter contains ideas mainly from fully qualified GPs. However, I have not excluded GP-trainees' accounts of clinical practice. Neither would I claim that education was not on-going in the qualified participants' biographies. Continuous professional development is an increasingly stringent (and unavoidable) condition of professional regulation (I have discussed ethical components of general practice appraisal and revalidation separately in the preceding chapter). Therefore I have regarded all accounts of practice as legitimate sources of data for this chapter.

In this chapter I examine ethical encounters in general practice in terms of the encounter rather than the substantive issue (some of which I will consider in the ensuing chapter). In the first part of the chapter I discuss recognition of an issue as ethical. This is tied in with participants' responses to the questions on a theme of 'what is' and 'what makes' an ethical problem. Participants described two broad ways of recognising ethical content in their professional lives: There was a conscious identification of specific issues which had been pre-

labelled as having an ethical aspect and types of problem that might be consciously identifiable as ethical, such as 'ethical dilemmas' where there is a clear conflict of two or more ethical principles. However, there is also a recurrent emotional or subconscious element to the recognition of ethical issues in participant narratives. In the second part of the chapter I describe the strategies used by (or observed by) participants in the management of ethical issues as they arise.

I conclude by considering how the ability to recognise the ethical content of general practice and strategies for managing that content is connected to ethical competence. Ethical competence has previously been described as something that is progressive and linear. For example, Hamric and Delgado describe phases of ethical competence – and whilst their framework has been developed with American independent nurse practitioners (and not British GPs), it offers a logical structure that can be applied to the education of any clinician with some autonomy of practice.

- Phase 1 (knowledge development): learning ethical principles and topics as well as identifying appropriate forums for discussion.
- Phase 2 (knowledge application): involves application of ethics to individual cases
- Phase 3 (creating an ethical environment): with a paradigm of preventative ethics, practitioners take on a leadership role as they advise colleagues and develop local policies. Preventative ethics involves engagement with codes and guidelines, principles and issues enhanced by ongoing rather than episodic enquiry – aimed at the avoidance of moral distress.
- Phase 4 (promoting social justice within the healthcare system): where practitioners contribute to wider debates, e.g. whether assisted suicide should be permitted.

The successful implementation of such a linear progression is not evident in my participant data. Understanding the basic approaches that GPs have to the recognition and management of ethics will assist the development of better ethics education and support in general practice.

Identifying the ethical content of general practice

Ethical issues

Much of medical ethics teaching at both undergraduate and postgraduate level focuses on particular issues which society and the relevant professions have identified as being problematic. Examples of these can be found in any textbook aimed at medical students and they include issues such as euthanasia, or contraception for children. These may be identified as problematic because either they have been identified as theoretically problematic, such as where principles predictably conflict, or because practitioners have found them to be ethically problematic in the past. While and Atwood (below) refer to these as *identified* dilemmas.

Most obviously we need such a skill with *identified dilemmas*: [authors' emphasis] requests for termination of pregnancy or euthanasia, the temptation to lie to a dying patient, an encounter with an uncontrolled epileptic patient who insists on driving (While and Attwood, 2000).

The GPs participating readily discussed specific ethical issues, as well as cases where those issues arose. Issues are considered here as a means of recognising ethical content (In the next chapter I will consider the four dominant themes in terms of those issues). In the quotation below, for example, Dr W lists contraception as an area of practice that he identified as requiring him to apply his ethics education. He was also prepared to suggest that he had been socialised to think of related scenarios as ethical.

Dr W: I suppose the other things in terms of when I talk about dilemmas is probably what I'm thinking about so when people have contraception, that's the kind of typical scenarios that you're reminded of when you apply the four principles.

AP: And what do you think, like those dilemmas, why are they dilemmas for you?

Dr W: They are dilemmas I suppose partly because we're ... I suppose part of the way we've been socialised to think of those scenarios as dilemmas.

It is problematic for ethics education to restrict itself to certain issues that are labelled as somehow ethical. Issues and cases may not always been seen by learners as paradigmatic of principles that might be applied in different cases. There may be a mismatch between the issues that are taught and the issues that are encountered. The mismatch may because the scenarios discussed in educational settings are rarely encountered. Some issues may be rarely encountered, and some might be rarely encountered by GPs. For example, Dr W suggested that the scenarios favoured in educational settings might not be so common in general practice.

Dr W: I suppose when we think about ethics and when I think about ethics, the thing that springs to mind are end of life – end of life isn't a traditional GP issue in terms of, it's not day to day practice...

Certain extra ordinary types of issue in medicine might be more obviously pre-labelled as ethical, or as ethically problematic. Dr S, for example suggests that extra ordinary issues are easier to discuss.

Dr S: For example one does get cases like this in primary care such as assisted conception, let's say, or a saviour baby, or a decision to treat at the end of life. I think that, if you like there's an easier jump into an ethical problem from one of those kinds of things than from other more ordinary.

There was consensus among participants that ethically problematic aspects of practice might be more easily identifiable in secondary care. The extraordinary examples cited by above Dr S,

assisted conception and the 'saviour baby,' are arguably more likely to be encountered in specialist medicine than primary care. Dr L, a course organiser for a MSc degree in Primary Healthcare suggested the life and death issues of acute hospital medicine might be more easily recognised as ethical in nature.

Dr L: ...maybe the, you know, the hospital is very obviously acute care, life and death decision making, whereas maybe in primary care, the, the sort of complexities and ambiguities are more subtle, and therefore aren't seen as ethical dilemmas rather than, you know, this is, this is the sort of practice.

The implication arising in comparisons that participants made between ethics in general practice and hospital medicine was that much of the ethical content in hospital medicine might come (to an extent) refined by speciality, e.g. beginning of life issues in obstetrics, childhood consent issues in paediatrics and when the general good might override individual rights in public health medicine, to name but a few. By contrast general practice was described as a coalface (Dr O was one of five GPs using the analogy of the coalface).

Dr O: ...probably the ethical dilemmas are much sharper in secondary care, but nevertheless you sort of feel that one is right there at the coalface...

Professor A expanded on the idea that ethical issues in primary care might be more uncertain and undefined, because primary care itself and general practice are fields or spheres of practice which are themselves more vague or uncertain and certainly less predictable.

Prof A: The clearer the problem, the much more [easy] it is to define the ethical dimensions because... by the time it comes through a consultant, it's gone through a lot of those refining, so the consultant really only has to deal with the very narrow band of activity, the rest they leave to somebody else. So the ethical considerations are much more easily defined within, as the sectors

move up the primary, secondary, tertiary sectors, the problems get more, not that they're easier to resolve, and not that they're not any less significant, but they're more easy to define. So the difference between primary care ethics and ethics in other places is that the definitions are pretty hard and they are very interactional and they relate to a whole lot of values and other constraints. So that's, that's one of the big differences between situations, is the amorphous nature of primary care -and the unpredictable nature of it.

The ethical content of general practice was not only seen as harder to define but more unpredictable in terms of the issues that individual practitioners might face. An ethical issue or challenge may be unexpected, as Dr O illustrates here.

Dr O: ... sometimes one's patients will say the most surprising things to you, to make you question their values and what's important for, for that population.

Dr O talked of questioning the patients' values but a GP might just as easily find themselves questioning their own. This unexpectedness is difficult to remedy with education or guidance that is aimed at specific circumstances, or even forethought about what one might do.

Dilemmas and other identifiably ethical types of problem

One way in which ethics education caters to this problem of not being able to foresee and solve specific problems is by the inculcation of general principles and the ability to recognise ethical types of problem, such as conflicts of interests and principles, or dilemmas. To compare this with the above section the method of recognising ethics is not, "This issue is likely to be ethically complex", but "The presence of conflict, or uncertainty as to what to do, has an 'ethical' character to it."

Dr W: I suppose more as a – actually when I have a dilemma, that's when I tend to think about [Ethics] more explicitly.

A dilemma might be perceived by the participant where a solution was not evident to them, even if might perhaps be evident to others. The word dilemma was generally applied to any ethical issue which provoked anxiety, distress (there was a solution which was emotionally challenging) or comment on the part of the moral agent. It was also applied to certain issues which had been identified in advance as being ethically contentious. True philosophical dilemmas are much rarer than the ethical conflicts that arise in medical practice. Conflict is possibly a better term than dilemma to describe the kinds of situations identified with ethical content, as While and Atwood illustrate below, even if the word dilemma is used frequently and loosely.

Most dramatically, we need [the ability to make moral judgements] when there are *conflicts* [authors' emphasis]: a patient makes a difficult demand, partners [in practice] fall out, or a [Primary Care Group] board faces a choice between two vital services (While and Attwood, 2000).

Dr B provided what he considered to be a dilemma in abstract form. The quotation below very much identifies a key problematic aspect of general practice being the conflicts of personal interests that arise in the context of family medicine.

Dr B: One would be very much the interest of patient A versus the interests of patient B, typically where you have a number of members of a family on your list. And you may be advising the different members of that family, quite separately, or you may be advising them together. And there may be times when something you maybe feel is in patient A's interest, is not in patient B's interest. And so that would present a dilemma. And that would be the dilemma obviously that the GP is not in a position to resolve. The GP's role almost certainly would be to facilitate the different patients' thinking in a way that is, is both enabling each family member to flourish as

best they may, and is also, is also intervening in a way that is, is just, with respect to their different interests.

Whilst Dr B's abstract example above may be a representation of the kind of 'dilemma' routinely faced by general practitioners, it some not appear as immediate and as dramatic as some of the life-and-death issues discussed in hospital medicine. If anything it is a 'life' dilemma rather than a 'life and death' one.

Dr O referred to the conflict between principles rather than between people. Whilst a conflict between the principle of equity (treating people fairly) and of respect for patient autonomy

Dr O: I find that equity is absolutely fundamental through all my work as a GP [...] and I find it of paramount importance. And I fear that many of my patients might object that I consider it too much in relation to their needs for patient autonomy. I don't find the two mutually exclusive. Again I don't know if I'm blurring the boundaries, but for me being a general practitioner is about, you know, fundamentally about managing resources, being a gatekeeper of resources and directing resources parsimoniously to those who need it. So equity is of fundamental importance, I consider, in my work.

Participants described a variety of types of encounter with ethics in practice, only some of which might be considered to be a dilemma as defined in philosophical theory. Dr M expressed frustration that ethics should be perceived by the public solely as dilemmas. In the comment below she distinguishes between problems, challenges, and dilemmas in primary care.

Dr M: So I had a conversation with [broadcast media producer], and she was saying, 'Can you give me some examples of problems in primary care.' Now I gave her some examples which thought were quite problematic and quite difficult but immediately it was, 'Where is the dilemma?' And

you see if you only focus on dilemmas you leave out a whole raft of ethical challenges and problems....

Educational approaches to ethics in medicine tend to cluster around a specified set of issues, or a particular type of problem. Even if, as the above data suggest, the issues can be more tailored to practice context, and an exclusive focus on dilemmas excludes more subtle ethical content, there more to discuss about such approaches. Firstly such education that there is may have relatively poor uptake. Also it may be seen as a classroom exercise. Professor P illustrates the idea with his comment below.

Prof P: Most people don't really know very much about ethics or engage with it as a structured intellectual exercise or they engage with its practical realities

The engagement with the practical to which Professor P refers might not involve any conscious reference to ethics education, and there may be no formal knowledge.

Prof P: I suspect that the majority of GPs very rarely have any kind of structured approach or framework or underlying theories to help them to deal with these challenges. So that's just seen as the challenging, demanding parts of doing the job, rather than, you know, a core element of what it means to be a GP.

Professor P's comment is in keeping with the idea that much of the ethical content of general practice is scarcely noticed (Misselbrook, 2012). Thus, the other way that the ethical content of practice might be recognised by a practitioner, is by the presence of difficulty in making a decision, or emotional discomfort. This is discussed in the next subsection.

Emotional and visceral dimensions of ethical awareness

Three participants described the recognition of ethics in practice as an altogether more instinctive process than the recognition of pre-labelled issues or types of dilemma. Encounters

with ethical content in practice were described as (for example) a sinking feeling, feeling suddenly depressed, or a pricking of the conscience or a sixth sense. In the quotation below Dr R describes a fairly visceral recognition of an impending ethical issue.

Dr R: [Eminent GP] once said to me, 'You know there's an ethical dilemma coming your way when you're sitting in a consultation and you get a sort of sinking feeling in the pit of your stomach.'

All three GPs, Drs R, U and S are experienced GPs and all have at some point been involved in the direct supervision of GP-trainees. It is possible therefore that they are well placed to observe the phenomenon, in themselves and others. In the quotations below Dr U and Dr S do this.

Dr U: I start grabbing for my ethical safety net, when I start finding that I'm getting distressed about how a patient's coping or not coping with a problem.

Dr S: ...The learner may have a sort of sixth sense that something is pricking away at their conscience or not quite right...

The idea of discomfort as a signal that there is an unexamined ethical problem is one which has found mention in general practice professional literature.

Most commonly we have *feelings of discomfort [author's emphasis]*, which alert us to something which is not right in what we are hearing or doing (While and Attwood, 2000)

Emotional discomfort, as well as being a way in which participants identified ethical encounters by themselves, also sometimes prompted them to elicit others' assistance in

identifying the ethical component of an uncomfortable consultation. One of the ways that this might happen is in a Balint group. The *raison d'être* of a Balint group is that participants bring cases (where they have felt uncomfortable or perceived something amiss) to discuss in the group. In the context of this study this would be a group of GPs or GP trainees led by a person with training in the Balint method.¹⁹ The unique quality of the Balint group method is that it provides an opportunity for doctors to examine the nature of their work from a de-medicalised perspective. The Balint group is not primarily intended as an ethics forum.

Dr R: I think the Balint group is not designed to do that. It's designed to look at something quite different which is to look at things where there are unconscious issues that are clouding the matter, and to try and understand them better... And that sinking feeling in the pit of the stomach is sometimes due to an ethical dilemma is one of the reasons why people might bring a case to a Balint group, but I don't think in my experience, which I don't think is that enormous –I haven't been in that many Balint groups regularly for a very many years- you don't get stonkingly obvious ethical dilemmas in Balint groups. Though there may be an element of ethical discomfort that may emerge in the analysis, but there is usually more to it than just ethical discomfort.

The first point worth extracting from this quotation is the idea that the discomfort generated by an ethical dilemma potentially leads to the issue being raised in the Balint group. This may be a reason why the exposure of ethical issues is sometimes associated with Balint groups (Kjeldmand and Holmstrom, 2010). Ethical issues can cause emotional discomfort, and a GP might lack the language to express an uncomfortable problem as an ethical problem.

Dr M: Especially if you're not well versed in the whole, you know, language and understanding of it, and a lot of emotions come into it. People feel uncomfortable about certain –they may even say 'I don't feel comfortable. I feel angry. I feel upset, I feel distressed by this situation'

¹⁹ Michael Balint was trained as a psychoanalyst and the method is heavily influenced by psychoanalysis.

Dr R suggested that those who brought an ethical case to a Balint group might not be aware of its content, only the emotional discomfort. By contrast, if they knew that the issue was an ethical one, they might instead discuss it with an appropriate colleague.

Dr R: A recognised dilemma, I would have thought that probably the most common thing people do, certainly the most common thing that I do and that people that I've worked with, I've come across people that I've worked with that have come to me about it – just find somebody and go and talk to them about it.

The second point is that the ethical issues Dr R associated with the Balint group are not obvious ethical dilemmas. Dr M described them as being framed in terms of clinical decision-making.

Dr M: Even Balint groups you see. They often raise ethical issues... Boundary issues. How much, what should I do? How far should I go? -that sort of thing...

AP: Would [issues identified in a Balint group] be labelled as ethical at any point?

Dr M: It depends, sometimes yes sometimes no but it's more 'I have a problem what should I do?' Yeah. It wouldn't necessarily be 'I've got an ethical problem'. Sometimes it might be [that] they would define it that way but not necessarily

The point illustrated by the above quotations is that emotional discomfort may be associated with situations in practice that have ethical content. Some participants above such as Drs R, U, and S used the discomfort as a trigger to think about ethics. Drs M, S and R suggested that GPs in training or with less experience in thinking about the ethical content of practice, might not have the language to express ethical causes of their discomfort, or might not recognise the discomfort as ethical in its origin. Balint groups are overtly connected to the idea of analysing unconscious sources of discomfort in the company of others. A possible confounder when

talking about Balint groups is that some people might consciously miss-use the Balint group setting as a safe place to discuss ethical or legal problems arising out of consultations (Kjeldmand and Holmstrom, 2010). As Dr R suggests the Balint group is not necessarily designed for that purpose. The Balint group is a safe setting, similar to that experienced in education.

Educational materials for GPs acknowledge the emotional nature of ethical issues and the recognition of ethical content (Gillies, 2009). Much of what is regarded as ethical is recognised unconsciously via emotional discomfort, and there is a need for a safe forum to discuss sensitive ethical issues. So if we buy into the idea that ethics in general practice is about patient centredness rather than protecting doctors' professional autonomy it is arguably appropriate to use a tool like the Balint group to expose ethical issues that may have been sub conscious. A number of participants, unsurprisingly among those who I had selected for their involvement with ethics as an educational or academic concern, describe such a conscious recognition of ethics 'as it comes through the door'. Dr S illustrates this.

Dr S: I would say that [the MA in medical law and ethics] made me much more aware of legal and ethical material as it comes through the door, and arguably of how to practice with more awareness of the law, with more awareness of moral thinking or moral decision making by clinicians. More awareness of things like trust relationships between doctors and patients...

Someone such as Dr S with awareness of what issues could be classified as ethical or analysed using ethical tools. There has been research supporting the idea that doctors with ethics education are more confident in seeking assistance with ethical issues. It is slightly disturbing to think that those without such education are less likely to seek assistance or to know how to – a principle analogous to Tudor-Hart's inverse care law. The inverse care law encapsulates a phenomenon where those most in need of healthcare are less likely to

access it, because of problems with access, whether services are simply unavailable, or inaccessible because of social or educational factors (Papanikitas, 2011a).

Too much emotion- a caveat

As I discussed above, emotional discomfort is a manner in which both participants and the professional literature recognised issues that could be ethical in nature. The acknowledgement of emotion and the subconscious in the consultation is (in theory at least) an established core feature of British general practice. During my general practice training for example, I attended a training session which used film, poetry, art and music to enhance the training group's sensitivity of bereavement and loss. However, for some participants, such sympathy or empathy risked compromising rational ethical decision-making. Dr U illustrates the idea that too much empathy may have a paralysing effect on the trainee's ability to think through a patient's issues.

Dr U: Okay, well, this is something we all face, because we've all got grandparents who die. And it can be a very profound and distressing thing. And again if the registrar is identifying too closely with the emotions of the patient at risk, they can get themselves in a muddle and stuck.

Dr D suggested a danger of relying solely on her own empathic distress as a moral compass, namely that her response might be disproportionate.

Dr D: I'm quite emotional about human beings and people and how they feel. I think I sometimes second guess how they might feel. And feeling more pain for them than they actually feel...

Dr D suggested that in the absence of a moral theory, she did too much, even when it was of no use.

Dr U and Dr D saw an appreciation of ethical theory, even at its most basic level, as offering a way of tempering a purely emotional response.

If ethical issues were recognised by discomfort, anxiety or even depression (all words used by participants), then it reasonably followed the ability to negotiate these encounters might be a source of relief.

Dr D: I think it makes it a bit, it helps clarify things in general practice ... medical ethics clarifies things for me. And keeps me sane.

Dr U also quite clearly described ethical frameworks introducing dispassionate rationality into decision-making. In the comment below he described ethics as preventing GPs from becoming compromised by the emotion of an emotionally troubling case whilst at same time reminding clinicians of their expectations.

Dr U: And then, one way of helping them is to go, because you can use the ethical framework as a way of pulling back from the problems and emotions of the issue, and say, 'Look let's look at the values behind all this, emotions, if you put them in a box, now look at this coldly.' And this helps, helps them manage the problem.

The role of emotion in the identification of an engagement with ethical issues was referred to by Gillies in an educational article for GP trainees. He reiterates both the idea that emotion can identify an ethical issue *and* that reasoning skills are needed to guide GPs to the best decisions.

Ethical discussions, especially in medicine, often bring out strong emotions. It is arguable that the nature of ethical debate has developed to enable us to discuss emotive issues without resorting to emotional manipulation and blackmail or even physical violence. However, this does not mean that emotional responses are not ethically relevant. These responses, often felt as intuitions, will often point us towards areas of ethical difficulty, which we ignore at our peril ... If we deny them,

we are effectively denying part of our humanity. We are unlikely to communicate effectively with our patients in general practice if we are suppressing our emotions completely, or if we are, our patients are certainly likely to be aware of it. At the same time, we need to be aware that these responses may not automatically guide us to the best decisions; they need to be subject to argument and discussion (Gillies, 2009).

The key insight from discussions around the identification of ethics content is that the identification of any aspect of practice as being ethical in nature allows the use of analytical tools, and ethical support and resources to be used. The identification of ethical issues as more broadly problematic or emotionally distressing can prompt their identification as ethical only if the person experiencing them seeks help and those issues are then identified. Accordingly, GP trainers and Balint group leaders ought to be able to recognise when an issue is ethical in nature and at the very least, to signpost the person experiencing ethical difficulty to appropriate support. Identification is not enough to allow GPs to fully function as moral agents. To see a problem, or even to be able to frame and classify it, and not know what to do about it is itself a source of distress. GPs need some ethical tools to make decisions with and resources to access when the decisions become complex or otherwise challenging.

Ethical Strategies

Having recognised aspects of practise as a GP to be ethical, the participants in this study identified a number of ways that they and their colleagues might approach such aspects. In the ensuing section I examine and classify those strategies. I have concentrated on the broad approaches to any ethical encounter – by encounter I mean any issue or aspect of practice – rather than participants’ responses to specific issues. For example, some participants hinted that a potential strategy is to avoid ethical encounters, whilst others talked of deferring to guidelines or consulting colleagues to whom they attributed wisdom or seniority in the workplace hierarchy. Some participants deferred to a set of rules. The law and the GMC’s good medical practice represent such a set. Others deferred to wise counsel or hierarchy. I have classified the ethical strategies in terms of level of engagement: avoidance, deferral and validation, and ethical engagement. Where evidence has emerged from participants’ narratives I have also considered what aspects of the workplace environment shape the adoption of particular ethical strategies.

‘Go for closure and walk away’ (Avoiding the issue)

One way of avoiding dealing with an ethical problem, dilemma, or issue is simply to not engage with it. None of the participants suggested that, having recognised an ethical issue, it was good practice ignore or avoid it. However, some did hint such a strategy was a potential option.

Dr U: So if, you know, you’re feeling in a fairly benign mood yourself and then suddenly you start getting worried about what you’re hearing, then, you know, you’ve got one of two choices, you

can either just ignore it, you know, and go for closure and walk away, or, the more responsible thing to do is to actually look at it objectively and from that you then go back to your ethical principles.

For Dr U the more responsible choice was to examine what was problematic. However, Dr D, a much younger and less experienced GP, was reluctant to be drawn in to matters which she considered to be ethical.

Dr D: I don't think I consciously use ethics as my decision making, because rarely do I, am I drawn into such situations.

Dr D describes the reluctance a GP might have in exploring whether or not a person is entitled to care or to state benefits. One way of avoiding a discussion of whether someone is entitled to benefits is simply to sign relevant 'sick-note'.

Dr D: I'm turning a blind eye where benefits and people are working and they're coming to see me and asking for sick notes ... That's one, but I don't know how to get out of it, because I speak to my partner and my partner says, 'Your job isn't to be a politician and try to save money, yours is your patient, therefore if they come and see you and they are sick, even if they pretend they can't walk in front of you, you have to do it to keep the harmony between you and your patient, because it's the bigger picture.' It doesn't sit right with me.

Dr D's senior partner may be avoiding certain types of ethically complex discussion. It is unclear whether the 'bigger picture' represents the smooth running of the clinic and more satisfied patients or an ideological commitment to one's own patients in preference to others using the NHS.

None of the examples given above are intended to suggest that just because a GP wishes to avoid moral agency on one issue, they wish to avoid moral agency in every circumstance. Dr B felt that it was not the role of the GP to 'Run people's lives' and he used this idea to distinguish his personal conception of right and wrong from that of professional ethics. When pushed on whether he might intervene in a case of repeated domestic violence he maintained that whilst he would facilitate engagement with social services and police, he would not do so without patient consent unless he felt autonomy was compromised, and went on to give a number of factors which might compromise that person's autonomy.

Where a GP uncritically takes a particular position is this an ethical preference or a reluctance to take a more critical look at the issue? Dr D's senior partner appeared at first glance to prioritise the patient in providing evidence for benefits on the basis that 'GPs are not politicians' and therefore not in a position to make resource allocation decisions.

Dr D's senior partner was, however, inclined to 'give them what they want', something which did not 'sit right' with Dr D. Several participants saw part of their role as GPs as not being wasteful with public resources. Dr D recognised that they might not have a right to the benefits and she might not be in a position to decide whether the patient was entitled or not. Dr D gave several accounts of resources being finite. Professor Z's partners in practice prioritised giving patients what they perceived to be the best option. Was this because they were committed to paternalist beneficence? Or was it because this allowed them to run their clinics to time, and offering options in an autonomy-enhancing way too burdensome?

So does the simple prioritisation of (for the sake of argument) patient autonomy (giving the patient what they want), or medical beneficence (telling the patient what to do) represent

1. Ignorance on the part of the moral agent?
2. The moral agent's ethical preference?

3. The moral agent avoiding the issues because of personal or structural issues?

It is not possible to answer this question with empirical certainty, as it is not possible to literally read the minds and 'see' the motivations of participants. However the data does hint at the possibility that one potential approach to an ethical issue is to avoid it. Another is to defer moral agency to others, and this will be considered in the next section.

Time was raised many times as reason why an ethical issue might not be explored. A lack of time may make ethical awareness or engagement complicated, difficult and inconvenient, and even ethically problematic. Time involved in thinking and reflection was mentioned many times by participants.

Avoiding difficult consultations or dismissing complicated problems could also result in an increased burden on others. Professor Z discussed the idea that practising in a more ethically sensitive manner might be inconvenient for others. Professor Z espoused a practical commitment to patient autonomy – he spent more time with patients giving them a sense of their options and empowering them to choose. He was prepared to reflect on why his more rigorous approach to autonomy might itself be morally problematic.

Prof Z: Well insofar as we discussed it, it tended to be more discussed in sort of jocular terms than in, you know, a substantial medical ethical analysis terms. But insofar as I could pick out, the two objections – one was a perfectly reasonable one, that I took too long to do all this, and that was a distributive justice issue, as I saw it. I was a long consulter rather than a short consulter and people would have to queue and the others who stuck with the ten minutes, felt a bit pissed off I suppose that I was causing people to wait and the dissatisfaction and so on. And the other was that in any case, you know, people came to doctors really for being told what they needed and get on with it, not for discussing, discussion about, about what they needed.

The difficulty of attending properly to ethical issues because of time pressures was something that one participant was able to avoid. Dr U was the exception, and only by practising in the different context of military general practice could he luxuriate in the time available explore to possible issues:

AP: Is there, do you ever feel sort of, do you ever feel hesitant to, as it were, open a can of worms?

Dr U: Happily no. The reason I don't is the timeframe. I mean the other thing I forgot to mention about the military is, it's luxury, the pace, the pace of work is 15 minute consultations and you don't always fill – so whereas I can guarantee in three hours to see 20 patients in the NHS land, sometimes in the military, I can be there for four hours and see six people. So if one came in and was obviously in trouble, it would not be difficult to give them three quarters of an hour. And that is a long time.

AP: Okay, so there's a disparity of resource potentially between the two environments.

Dr U: Yes.

Whilst in the military context Dr U also had fewer complex problems competing with his time, as well as more available time at the outset, he did see conflicts of interest and had cases that merited exploration. Available resource and time made this job considerably easier, however.

'Just Tell me what to do and I'll do it' (Deferred Ethics)

The participants were generally happy to defer moral agency in a number of situations with ethical content. Deferral might involve following a set of guidelines or rules or it might involve following the advice or instructions of an expert or senior colleague. Just as medical educators were prepared to talk to me about trainees and students, clinicians were prepared to share observations about colleagues' comments and behaviours. Professor P, a senior (salaried) GP and medical leader described a moral deference which he felt was a new phenomenon. For Professor P this phenomenon of deference to management and guidelines went beyond general practice and applied to the medical profession as a whole.

Prof P: Now, surprisingly, I think, I think professionalism, there's a different model of professionalism emerging in which, rather than wanting and seizing a degree of autonomy that our forefathers would have wanted, people want to be told what to do. There's a kind of passivity, I think. So people want to, maybe passivity is wrong, people want to be told what to do by managers, they want a strict framework within which to operate because they don't have time or energy or inclination to have discussions about issues. They want to be told what to do in clinical practice, so evidence based medicine is easy medicine to practice. So I think, I think yes, I think it doesn't surprise me at all if people feel the same about ethical issues, 'just tell me what to do and I'll do it,' is a common response from, not just from general practice, but from doctors and health professionals of all sorts, which I think is distinctly unhealthy.

Dr F: Some GPs just want to get on with it. Some GPs just want to work two days a week and just be a GP, aren't that bothered about the decisions.

This observation appears to challenge the entire *raison d'être* of ethics education, if education is to be more than learning the rules. Professor P suggests that doctors (and GPs) are less

prepared to engage with and discuss ethical issues than they once were, and that this is because they do not have the time or energy to do so. The strong implication is that they are thereby deferring some if not all of their moral agency to a set of rules or a person with seniority in the workplace hierarchy. As such there is less interest in learning and understanding the vocabulary of ethical analysis. The self-imposed ethical illiteracy of GPs which Marshall hints at may be akin to political illiteracy which Marshall has also commented upon (Marshall, 2009).

The following subsections will examine the types of deference described by the participants. The discussion of deferral falls into two parts: deferral to instructions such as codes, rules and guidelines and deferral to people such as workplace seniors and experts.

Deferral to instructions

The majority of participants made extensive reference to rules and codes in terms of the manner in which they signpost ethical boundaries in practice. Miller distinguishes between three types of ethical code that are commonly used in medical education (Miller, 2000):

1. Statements of core values [which] are simply lists of moral values. They may or may not include some minimal explanation of what is meant by each of the values listed.
2. Oaths [which] also concentrate on values. Although they usually do include some behavioural advice, this advice tends to be very limited in its detail.
3. Deontological codes of ethics [which] are detailed expositions of what constitutes good behaviour. The GMC guidance for UK doctors, Good Medical Practice is a good example: it extends to 18 pages and yet is still not completely exhaustive.

In discussions with participants and in my own experience as a GP I found very little if any reference to types one and two of Miller's categorization having impact on day-to-day ethical decision-making. By contrast there was much reference to codes of practice, particularly to 'Good Medical Practice'. In this section I begin by considering statements of core values alongside oaths which concentrate on values. These were hardly mentioned except where participants dismissed them as superficial nods to a medical tradition. The second type of code is the professional code of conduct outlined in the document, 'Good medical practice'. The latter document has a quasi-legal status in that doctors who do not conform may be ordered to correct their behavior or do additional training and/or be prevented from working (or 'struck off') if they do not comply. I consider following rules and guidelines as a form of deference here. I will argue very simply that that it is much harder to defer to values or to ancient oaths than to modern deontological codes of ethics. Moreover guidelines for situations of ethical complexity and medico-legal risk are a highly attractive – they ostensibly offer a safe path through the moral maze.

The Hippocratic Oath and deferring to values

Despite references to the Hippocratic Oath in educational materials, references to the Hippocratic Oath were strikingly few. However, the Hippocratic oath is mentioned here because whilst they might not have sworn the Hippocratic Oath some of the GP population will have made declarations based on watered down versions of it, and new graduates in the UK do generally make a public declaration affirming the principles set down in the GMC's document good medical practice (Richards et al., 2006).

The quotation below, taken from an article in 'The Practitioner', a journal for GPs, by a GP who has been a practitioner, educator and academic, suggests that healthcare professions espoused values via rules and codes.

Roger Higgs: Traditionally the health care professions have fallen back on to rules or codes derived from oaths like the Hippocratic, changing little over the centuries and backed up by the gradually evolving traditions of practice ... The benefit of the patient was a major consideration but it was the physician who decided what that should be. The picture was of the profession looking out of its shop, and making sure the window was tidy (Higgs, 1985).

Higgs uses the metaphor of the shop window to illustrate how a profession might put its ethics on display. Participants referred to values in the Oath still having currency in general practice, such as Prof A's comment.

Yes, what kinds of situations do you think of when you hear the phrase, 'ethical issues' in general practice?

Prof A: Well I think, I think people relate to do no harm, the first one. I think the bottom line of what most GPs would think was Hippocrates, because that's supposed to be the oath they take and that's the place where they last and do remember. And then maybe Asclepius and then after that, it's, it's about doing no harm. I think that's what GPs have related to.

Only one participant, Dr N, a general practitioner who had initially trained in a formerly communist country, reminisced that though she and her classmates had all sworn the Hippocratic Oath at their graduation. For Dr N and her colleagues this was a quaint tradition associated with a very superficial engagement with ethics, and with no sanction in the face of transgression. It is possible, however for some who swear versions of the Oath to be morally invested in its key principles.

Dr G reflected that whilst British doctors do not generally swear the Hippocratic oath, there is a public perception that they do.

Dr G: And I mean, in the context of ethics, and if you go back to the, to the Hippocratic Oath, which obviously, to this day, many lay-people still think that doctors swear to, which of course they don't any more.

Dr G went on to reflect on why the public might like the idea of doctors swearing an oath of commitment to honesty, professional integrity and beneficence.

Dr G: But the content of that, I think, is remarkably interesting, in that, that's a wonderful mix of, of, of deontological principles, you know, to do with, 'this is right because the gods will it.' You know, and some of it enormously pragmatic, like, 'don't rape the servants because you'll get into trouble,' which features in the oath, as you know, 'on house calls'. And so, so somewhere in that whole background, there seems to be a very interesting mishmash of origins, I mean based on the idea that somebody in the professional role, almost by definition, is expected to have some kind of code of values which people can see in advance and have trust in, with all the thrust of professionalism, which is something I've done some work on, is to do with trust and how you remain trustworthy. What it takes to remain trustworthy. But the origins of what it takes to remain trustworthy are a curious basket of things, most of which I suspect are fairly obvious, like if you're in a helping profession, it's probably better to help than to harm. And that doesn't have to come down on tablets of stone. But a lot of the detail, I think, is very pragmatic.

If GPs do not defer to Hippocratic ideals when deciding on a course of action, this may be down to a lack of perceived relevance to current practice. The Hippocratic Oath has been entirely supplanted in the UK by the GMC's 'Duties of a Doctor.'

Deferring to rules

Ethical rules, guidelines and policies are all examples of preventative ethics. Based on the premise that some people with authority and or expertise have considered problematic issues and produced rules to navigate the issues – GPs could defer to rules of conduct rather than agonise over each and every case. Dr B provided one such example.

Dr B: But I don't think there are a lot of huge ethical dilemmas in general practice terminal care, because most of those have been well discussed and are 'resolved', in inverted commas, through the appropriate use of guidelines.

The guidelines to which Dr B generally referred were those produced by the GMC. These are, as Dr B sees it, quite nuanced with a lot of ethical scholarship and professional opinion incorporated. GPs might defer to guidelines either to take comfort in knowing that they have made a decision that is morally right, or in the knowledge that if they follow the guideline they may be less likely to be criticised. Suggesting that ethical guidelines are based on ethical principles, Dr W illustrated both of these ideas:

Dr W: So, you know, through training it's like, you go through the whole thing about greater confidence and being brought up with the concept that you actually need to apply the guidelines, because it applies an ethical framework...

AP [later in the interview]: Is it that you're, you feel you're making sort of better argued decisions or you're making decisions that are in keeping with a responsible body of medical opinion?

Dr W: Probably in reality ... it would be the latter.

AP: Okay.

Dr W: However, I mean, in your day to day practice, I suppose it's not – I'd like to think I'm not doing it as a defensive practice. What I'm doing is, is a facilitative way of reaching a decision.

However, a proliferation of guidelines could also be counter-productive if not accompanied by the means to prioritise guideline in the case of conflict between them. Dr G suggested that conflicts may be generated by a proliferation of guidelines in general

Dr G: For instance, I do genuinely believe that the effect of [the quality and outcomes framework] has been to put a lot of doctors under quite serious ethical dilemmas, as to their priorities with patients in the consultation. I think that's a very real issue. And probably things like organisations like NICE and Healthcare Commission and so forth, which are intended to resolve some of these dilemmas, they actually I think intensify them, because they heighten the tension between individual prescribing decisions and the way you might want to advocate what you perceive to be an individual patient's best interest, which is conflict or at tension with the whole public health perspective.

For Dr G it appeared ironic that guidelines which were intended to resolve dilemmas might actually intensify them.

Professor Z, a retired GP and eminent academic, argued that doctors in general require guidelines, and that these guidelines should incorporate ethics. For Prof Z, knowing and following the guidelines is important, perhaps more important than being able to understand or critique them.

Prof Z: ...I think the GMC has done a really good job in integrating medical ethics into practice in its guidelines. And the only problem is, of course, that how many people actually read the guidelines, let alone how many people actually follow the guidelines in their practice.

So, according to Prof Z much of the moral work has been done for the GP, and some of their agency has been deferred to the General Medical Council.

Professor Z and Dr B were particularly emphatic that in the case of the GMC guidelines the rules themselves were worth buying into.

Prof Z: ...I'm very impressed with the amount of ethics that is now in the GMC guidelines of various sorts. And indeed increasingly think that if doctors actually carried out the GMC guidelines as their basis for their practice, medical ethics would have, in reality got *incorporated* much more into medical practice than was ever the case before [...] and if you really read them and *incorporate* them into your practice, you'd be a darned sight better doctor.

Professor Z talked of ethics being integrated 'in' the guidelines and ethics being 'incorporated' in practice. In terms of outcomes (i.e. avoiding complaints and litigation) doing as the guidelines suggest seems perhaps more important than being able to critique them. Dr B, a Senior Urban GP Partner, trainer and educator echoed the sentiment that all good doctors should know the rules.

Dr B: Yes, I mean codes of practice are very important for a number of reasons. They're mainly important, I guess, because they set out a boundary, beyond which thou shalt not transgress. But certainly when they're as highly worked up as GMC's say, Good Medical Practice, then it's more than just a boundary, it's talking about some of the stuff that lies within that boundary. So I would view that as a very helpful document. And I encourage my trainees to read it.

It thus seems unsurprising that, when revising for their general practice exams, Dr Q and his colleagues reached first for the GMC booklets that stated the duties of a doctor.

Dr Q: No really we know just from word of mouth that the oral component of the summative assessment, a lot of it involved ethical issues, so we got hold of the appropriate type of books that we got from ahh... um... that we got the GMC, do you remember those little books that they did there were four or five of them: Confidentiality, data collection, and all that sort of thing and just sort of read through them.

Echoing Professor Z, Dr B expressed a preference for using the GMC guidance rather than the relevant RCGP curriculum statement:

Dr B: For what it's worth though, I view Good Medical Practice as a more interesting and relevant document than the RCGP curriculum. But, sorry that's a mildly personal and heretical statement.

At the time when Dr Q and his colleagues sat their professional examinations, they used General Medical Council booklets that identified key 'duties of a doctor' and provided supplementary guidance on issues such as confidentiality. According to Dr B, juniors need to learn the rules and seniors need to revise them from time to time:

Dr B: So if you like, to my mind, codes of practice would be a fairly sort of primary school thing, a setting boundaries thing, an initial colouring in some of the spaces thing, that, that juniors need to do and seniors need to remain aware of and, you know, revise from time to time.

The key point here is that ethical rules and guidelines are wont to change. For deferral to guidelines to avoid criticism GPs need to keep up to date with those guidelines. Learning them once and then internalising them will not be sufficient.

Qualified deferral

Participants talked of following rules but they also described a need to know when to deviate from them. Situations may be more complex than the rules have accounted for, and it may not be right to follow a rule or guideline.

Dr B: However, what you can't get in a code of practice, is any sense of what the experienced practitioner will actually be thinking and processing in complex situations. Or at least, to the extent you can, it's a fairly initial, initial broad brush approach at that... But I don't think it is in any sense a substitute for mature ethical reflection, which I think all doctors need to be encouraged to be able to develop.

Even whilst suggesting that the code of practice is more immediately useful than a curriculum statement, Dr B discussed mature ethical reflection. Is necessary to be able to be able to understand the basis of a code of conduct? If so should this be such that one can critique it, or explain its rationale to patients? A problem with ethical guidance is that if someone agrees with the guidance on the basis that they believe it is right, and then the guidance changes what does this mean for the GP?

Dr F, a GP trainee who was about to sit her clinical skills assessment, argued that GPs should be able exercise clinical judgement, and this included the ability to decide whether or not to follow a guideline. She used the analogy of guidelines from the National Institute of Clinical Excellence to do this.

Dr F: That's a bit like the NICE guidelines, isn't it? The NICE guidelines are clinical. You know, someone who's gone up there and come up with these guidelines and we should stick them, when actually not everybody, you know, a lot of doctors don't agree with the NICE guidelines and don't stick to them. So it could be helpful. But it might not. It's difficult to say... I'm not afraid to disagree. So if someone presented me with this formulaic, 'this is how you should be,' would depend on what it said."

Dr F felt that she was possibly atypical in wanting to take more of a leadership role. However she was not unlike Dr O in terms of her institutional connections. She also indicated that (ethical guidelines being similar to clinical guidelines) she might have difficulty following them if they were inappropriate or poorly thought-through. Here ethical competence seems more a

feature of moral leadership than an anxiety over a lack of supervision or a lack of clarity. Dr F did not make any explicit connection between ethical competence and the ability to critique rules.

Having every more specific and complex guidelines, does not make them easier for the practitioner to interpret. When I pointed out that a patient was probably entitled to correspondence that related to their care, Dr Q suggested that practical guidance for such situation could be clearer.

Dr Q: OK that's a good example. If that information was much clearer rather than using foreign language sometimes. What can we give the patient, what can't we give the patient...

Whilst there was a potential learning need on Dr Q's part, his description of ethical guidance as being a foreign language is suggestive of a way in which moral agency can be removed from the clinician. Technical language is by definition employed by technical experts.

Dr Q highlighted the idea that being able to analyse an ethical issue so as to make sense of it was not just about understanding the rules so as to 'buy in' to them as Dr F had outlined, but about being able to justify decisions to the public.

AP: So the message I seem to be getting from you, is that there's a lot of advice, and perhaps those guidelines exist, but they're not filtering through to the people who actually have to use these ideas and this knowledge.

Dr Q: Well they are not as clear cut or as simple as they potentially could be. It would be nice to be told that you can give this information to a patient or you can't, and give reasons why.

Clearly, ethical competence involves more than simple rule following.

Advice from others

This section (below) concerns another form of deferred agency, seeking advice. This was described as taking two forms. Some participants wanted to be given a clear direction to follow, whether this was in the form of leadership from their 'line manager', a guideline or an authoritative interpretation of their duties. Others wanted a prospective, inter-current, or retrospective validation of their thoughts or actions. Advice was sought from a variety of sources ranging from family members (medical and non-medical), trusted colleagues, and people employed to keep doctors out of trouble (medical indemnity advisors).

What should I do?

At the beginning of this chapter I quoted Dr F's anxious comment that she might be in a position of not knowing what to do when she qualified as a GP. She expressed an added anxiety about there not being someone to ask, "What should I do?"

Dr F: I'm actually worried, I'm scared, although I've still got six months to go, I'm worried that I'm going to end up being a GP come August and there will be ethical issues that will sort of – that will come my way, and I'm not going to know what to do. And sometimes you don't have the luxury of afterwards being able to make a phone call or being able to do something. You have to really think on your feet and think, 'Okay, you know, I need to address this with the patient now...'

...I think that GP training needs more, there needs to be more emphasis on the ethics, because I think as a, I think as a GP it's quite, it can be quite lonely and you're dealing with quite difficult situations often. And I don't know, I don't know if the support is there.

... in a hospital you have less control, you've got managers over you. In a GP, as a GP in terms of sort of the financial side of things, at the moment you have a pot and you can decide what might

be good and what might be bad. In a hospital a lot of consultants, they are limited by other people deciding things for them.

Prof A: Well the thing that I did like that never really took off in a big way is the notion of the primary care ethicist who provides a service for ethical dilemmas that occur in practice. That would be the service role. Just a bit like ... a counselling service for patients.

Some of my participants had developed unofficial reputations as ethics experts. Professor Y and S described being used as a source of ethical and legal advice. Dr R had a formal role in the practice as 'Caldicott guardian' – the person in an organisation who is responsible for checking that the confidentiality of personal data is maintained. Dr S also was sought for advice on account of being known for his ethical expertise.

Dr S: And my partners know that I've got 'allegedly' skills in this area, and quite often will ask me in discussion, you know, "What do I do with this incapacitous patient that I can't cope with?" - that sort of thing. So its value, I think, for the practice as a whole.

The idea of deferring to the senior partner was very much a response of the more junior participants. Trainees deferred to their trainer in a similar manner.

Dr D: ... I most probably follow whatever my senior partner tells me. The nice thing about my senior partner, is he tries to involve you with the top process, but him having almost 20 odd years of experience, I think, will actually give me an idea of what to do.

Ethical validation, or, 'Am I doing the right thing?'

The GPs in this study described a kind of deferral that was less advice seeking as it was ethical validation. They presented a decision which they had made or proposed to make and sought comment from experts or peers. This was described either as a formal process, often in order

to check that a decision would be defensible in the event of a complaint, or as an informal discussion in a familiar setting.

When seeking ethical or legal validation formally, participants valued a source of advice that was 'on their side'. It seems intuitive that the medical indemnity organisation would be such a source of validation. A handful of participants were prepared to discuss advice from medical indemnity organisations (MIOs). Dr D echoes the sentiment in the quotation below.

Dr D: Well I think I'd just call the [MIO] just to make sure legally I'm safe, whatever decision I make...

In his quotation below Dr B illustrates how he contacted his provider of medico-legal indemnity in order to verify that his legal and professional obligations were as he thought they were.

Dr B: ...quite a few years ago, the police came to see me and plonked down some photographs on my desk and said, 'Dr, do you recognise this patient?' And the photographs were from a security camera in the local bank. The patient I knew very well... The patient holding a shotgun to the bank clerk, and threatening to blow their head off! So that would be an example where - I was pretty sure that I knew the answer to that. This is quite a few years ago. So I said, 'Just give me five minutes, I'll phone my defence organisation.'

...Well, you know the [MIO], they're very good. I've always been very happy with their advice. They reflected it back to me, and said, 'Well doctor. What do you think?' And I said, 'Well it seems to me that there's a fairly, because the police had given a narrative of a gradually escalating level of violence and threat. This person had held up a number of local-ish banks and building societies, and there was an increasing concern that they were going to shoot someone.'

So it seemed to me fairly apparent that there was a very real danger to the health or even life of another party. And therefore that was a very good case where it would be both ethically and legally justified, and regulations wise, justified, GMC wise, to breach confidentiality. And that's what I said to the person on the end of the [MIO] like. And they said, 'Yes I agree with you doctor. If you do end up in court being sued by your patient, we'll be with you.' Which is in a sense, all I wanted to know.

Dr B wanted to know that he would be supported if his patient sued him. The support from the MIO is twofold – they will defend a doctor in court, and if the doctor is found guilty they will pay the appropriate financial damages on the doctor's behalf. Consequently any doctor who acts in the absence of unequivocal support from the MIO is being morally brave. I was fortunate to have a very similar case for direct comparison. Dr O also described telephoning such an organisation for advice regarding a similar case where he was also sure of his ethical obligations. Unlike Dr B, however, he did not get the validation he sought immediately.

Dr O: ...I did have a case in which I was asked for, asked by the police for information within records of a patient who had seen me... And I rang the [MIO] and the lawyer I spoke to [this would have been a medicolegal advisor, not necessarily a solicitor] gave me, I have to say, gave me very confusing advice. I really thought it was really straightforward, you know, okay this is a serious crime, no question of argument, just open up the file and let them see what they want. It really seemed very straightforward to me. But the solicitor from the [MIO], I don't know, seemed to be playing devil's advocate or something and made me very confused, so much so that I refused to open the file for the police. I said they could have it, but with all the bits you're interested in redacted. Anyhow, they came round again because this was a very serious crime. And someone said to me that legal proceedings were going slowly and painfully and I thought, "Well you know, I'm going to revisit this." So I rang [MIO] again and I got much clearer advice, much more in line with my original felt position. And the advice was that... if the police were there, then show them the file. And I have to say it resulted in a conviction.

The participants had varied views on the role of medical indemnity organizations as a source of ethics support. Dr E suggested that defensive medicine might be advocated by indemnity organizations, actions that might be less likely to result in legal actions or professional criticism but at the same time might not be morally courageous. Possibly deferring to an opinion that he disagreed with or passing the decision to someone else could fall into such a category. Dr B and Dr G both described contacting an medical organization as something one might be expected to do if one expected a patient complaint and an was more about ensuring indemnity cover than ethico-legal discussion – and not a common occurrence: Dr B stated he had telephoned his indemnity body four or five times in thirty years of practicing as a doctor. Dr Q had approached his indemnifier about a ‘salary’ issue but never about an ‘ethical’ issue. Support for professional dilemmas has largely been provided by medical defence organizations, themselves motivated by a desire to avoid costly disciplinary proceedings against doctors. Newly qualified and trainee GPs are encouraged to obtain legal and professional advice from their indemnifier for any case which they feel ethical or legal uncertainty over (Abrams 2005). This appears motivated more by a desire to avoid being sued in the courts or censured by the GMC than a sense of ‘doing the right thing’.

A much less formal way of checking that one’s ethics are sound that emerged was banter, or informal conversation. Dr Q mentions ‘banter’ with the senior partner in the practice or with colleagues as a way of resolving or discussing issues. It is unclear if the same ‘banter’ would take place with the senior partner as with the more experienced colleague or Dr Q’s contemporaries.

AP: How would you approach in general terms an ethical problem, having identified it as ethical or moral?

Dr S: I think about it... and I talk to somebody else about it, and I read around it ... I might talk to a colleague –the coffee conversation... and I’ve got a lot of time for that...

Dr S may have had more time because he was not in full-time practice, but he made a space within his working life to seek advice and (as someone with ethics skills) to give it.

An interesting and perhaps obvious source of moral support was family. I describe this a moral support rather than ethical support, because there was no indication from participants that the spouse, friend or parent described had any theoretical knowledge, or was anything other than a theoretic ‘sounding board.’ This is perhaps obvious and expected because moral concepts such as (for example) justice, promise-keeping, and honesty are not restricted to the healthcare. Participants did admit that they discussed work issues with medically and non-medically qualified family members. Off-duty discussion carried some hazard in terms of safeguarding the confidentiality of patients, but had the potential advantage of not being prevented by time-pressures.

What type of person might provide such advice?

Deciding who to ask for ethical advice is itself a problematic issue. At the second Royal Society of Medicine conference on primary care ethics, Suzanne Shale, reflecting on her interviews with medical directors, put the question to a gathering of mostly GPs.

Suzanne Shale: “...that the difficulty is, if you are a person who is seeking moral advice, that presupposes that you don’t know yourself what to do. It also poses the problem then of how do you know the right person to go to and ask for moral advice, how do you know that you’re

getting good moral advice, how do you judge the credentials of the person who is giving you that moral advice.”

The answer to Shale’s question, as it emerged in this study, was manifold. Many factors shaped the decision of whom to ask for ethical advice, and these were conditional on situation requiring advice, as well as the natures of the advisor and the advisee. Dr R, a much more senior GP with some expertise in philosophy and ethics describes this:

Dr R: There are some people you talk to about things like that and some that you don’t. It might depend on the patient and the situation. If you know – It might be you might come to some person because you know that they’re politically, they’ve politically got a good sense of moral nous. It might be because they know the situation and you may be looking for an insight, an understanding, a different understanding based on their knowledge of particular facts...

Medicine arguably has a culture of deferral to speciality when a case becomes extraordinary or complex. Professor P reflected on what was perceived as a possible widespread contentment that ‘clever people’ might do ethics on behalf of the average GP.

Prof P: And probably most people think [ethics is] something that intellectuals do or pointy headed people do and think about, it’s something that someone else is doing for them.

One of the trainees in the focus group made the suggestion that hospital specialists in a particular field might also have some ethical expertise with respect to any difficult case that touched on their speciality.

Dr I: I think you, if somebody urgently – if it was an end of life issue or something like that, you would always have clinicians in a tertiary centre, so there would always be a palliative care

physician you could speak to. Or if the patient was under some sort of specialist I guess you could speak to them.

So Dr I (above) might consider speaking to a palliative care consultant about an end of life issue, the rationale being that the consultant may have encountered the issue before in theory or practice or might be aware of facts that might alter the nature of the issue.

One such issue I have encountered is the issue doctors (including GPs) face when prescribing opiates or sedatives in an end-of-life context. It is used as a teaching example in the RCGP trainees' journal article on ethics. The question is whether a doctor may give a patient medication to ease pain or distress that might also shorten their life. The advice from many palliative care specialists is that, in most cases the judicious use of such medications is not life-shortening – and the 'dilemma' evaporates.

The idea that a consultant in a clinical speciality may also assist with ethical decision-making regarding that speciality may reinforce or contradict the perception that ethical issues are easier to define in specialist medicine (see above section on ethical issues).

The obvious source of advice might be someone who is paid to give doctors advice and keep them out of professional and legal difficulties, such as a medico-legal advisor for a medical indemnity body. Medical indemnity bodies were not necessarily preferable as sources of advice and support.

Dr G: in terms of right or wrong, I'm not sure that I would set the [medical indemnity] people or the local ethical people on any higher pedestal than many other people in my experience, in my circle. But what I do know is that, at least I think I know, is that for me to get to clarify my own uncertainty would be more effectively done in discussion with people that I know and respect

and trust and can feel safe with, which is not some anonymous expert at the end of a letter or phone call.

Dr G talks about trusting and feeling safe with the person who he talked to. The implication is that one does might not trust and feel safe with an organisation that might tell the GP that his actions were indefensible in court. There is also a stigma around complaints. This compares to anxieties around evaluation.

Some participants had also described seeking guidance from knowledgeable or senior colleagues. The deferral to the advice of a more experienced colleague or boss is referred to by Dr Q in the comment below

AP: If you had ethical issues that you wanted to discuss who would you normally approach?

Dr Q: Normally? Senior partner, colleagues, friends, who've had more experience. It a bit more of a banter really than anything else.

However there might also be reasons why someone might not wish to approach such colleagues for fear of criticism. Dr D, in the comment below, describes a colleague whom she would not go to for advice on ethics.

Dr D: You see, I feel, I feel very isolated because I'm new to the area, I've been here for almost two years, but I really, and it's only my partner and me – and I know another GP in another surgery, but she's very harsh. She would know all the ins and outs legally what to do, but I don't want her, I don't think I can approach her type. I feel very isolated, I wish I had good contacts with my old registrars and see how they feel. But I think the Royal College has just had their first five year programme, and I'm seriously thinking of joining, because I really don't know what I'm doing half the time, and there's no one to ask. Well there's my partner, my senior partner, but there are some things you don't want to...

Dr D's description of her colleague from the other surgery as 'harsh' and unapproachable is likely to reflect a. Dr D went on to describe the qualities of the particular person who she felt that she could approach to discuss difficult issues.

Dr D: Because he knows – I just feel comfortable with him and I know that he usually knows the ins and outs of everything. He's this slightly pedantic guy who would read every page and know everything there is to know, how to give the best care, and he is always very patient centred, and he will know how to signpost me to get help. He's always done that before. And he's also very kind, a kind person, non-judgemental, that's what I like a lot about [name removed].

Dr D also expressed anxiety about what she might feel if her senior partner advocated a decision she entirely disagreed with. Whilst junior participants somewhat predictably suggested they might talk to a senior colleague, senior participants were more forthcoming on the qualities of someone whom they might discuss an ethical issue with.

Dr G: I would need to know that their experience would sufficiently chime with my own for them to empathise with my dilemma. And I think I would probably want to have seen a track record in them of, of either being comfortable with that dilemma or similar dilemmas or having the approach to medicine from which a resolution was likely to emerge, and I think, for instance, my own trainer for whom I have the highest regard [name given] who's not necessarily been there, done it all, seen it and seen it all chap. His experience is vast. But I do know that his priorities are, are genuinely patient centred, genuinely thoughtful, genuinely intelligent, and that from the mouth of such a person is likely to come stuff that I would find quite helpful.

Later in the same interview he clarified what he meant by moral nous:

Dr R: Someone with moral sense that I find it easy to talk to ... A mixture of having an impression that they have a high standard or moral integrity themselves, and sensitivity to the nuances. I mean there would be no point in discussing it with someone who has a woolly either 'you obey

the rules' view or 'it's not a problem' and can't see the difficulty... So yes you want someone with a good dose of phronesis [practical wisdom] don't you?

Embedded Ethics and Unconscious Competence

Some participants described a category of strategy that is neither deferred ethics nor a fresh ethical engagement with the issues at hand. It is a form of practical casuistry, in the sense that one learns the right course of action from previous experiences as much as stories about the correct action, and then one applies similar actions in similar circumstances. This might be a conscious intuition, but might also represent the phenomenon of 'unconscious competence.' In Chapter 5, I referred to Dr G's description of learning the detailed anatomy of the groin and then only consciously using the information to know where to feel for the femoral pulse. I repeat it below.

Dr G: ...as an undergraduate we must have spent at least three weeks... agonising over the detailed anatomy of the femoral triangle. And having vivas about it, dissecting it and all the rest of it, and learning the anatomy of it, not many years on, all you need to know about the, about the femoral triangle is that you put your finger over the artery and stab medially if you want a vein. That's all you need to know. And at that point, although you probably needed to have been primed to appreciate that, in actual daily practice, most, a huge amount of what you learnt and agonised over as a student, is either redundant or has become so internalised that you can't see the origins of it any more. And I suspect... that quite a lot of ethical thinking is around there as well.

Dr B suggested that embedding ethical guidance and learning in this way might be necessary.

Dr B: ...I think real life is incredibly complicated, but one needs to understand at least bits of it and then build that into a fairly intuitive style.

An example of developing internalized rules as a combination of cumulative experience and reflection was described by Dr R.

Dr R: I remember one doctor when I was quite new in practice, she was some years, she was quite near retirement, she was probably about fifty, she was in mid-career, she was about fifty then, I think. And I said, 'How often do you think you come across an ethical dilemma in practice, [name removed],' and she said, 'Not very often because I've decided what, what I believe about most situations I come across.' And I thought that was interesting, that actually some of them are, are problems that once you've, once you've sort of sorted, you've unpacked them for yourself, and you've reached a position, you know what to do and they become less problematic.

Dr R also referred to V-rules, in deference to virtue-ethicist Rosalind Hursthouse. A V-rule is a rule for good conduct that derives from an understanding of virtues and vices. Dr B, a senior GP-trainer and course organiser, suggested that a virtuous style of practice might be developed with experience.

Dr B: ...to some extent, my [GP] partner, who doesn't work things through and hasn't read half as much as I have, hasn't read – actually probably the honest truth is, he hasn't read a tenth as much as I have. In many ways he is a better and more humane and certainly just as ethical a practitioner as I am, because his style relates very much to himself as a person, he is indeed a virtuous person, with the word 'virtue' in inverted commas to mean one who has developed excellence and steadiness of character and habit.

Toon argues that it is vital for the practice of medicine that impressionable students (I would add trainees in this category) are exposed to not just to practitioners with excellent skills in clinical practice but also to those from whom they are most likely to 'catch' the virtues of good practice (Toon, 1999a).

Whilst the acquisition and internalisation of practical wisdom was described as a virtue, it was also described as a way in which ethical competence might, or might become, unconscious. Dr R wondered if the practical wisdom demonstrated by the average 'good' GP represented this, and made specific reference to Johari's window, a term from educational theory.

Dr R: I think it's part of expert practice isn't it... – phronesis is part of expert practice. There is an interesting question about whether, which, which bit of Johari's window this sits in. I would suggest that there are a lot of extra doctors for whom this sits in the unconscious competence corner. And I think that's okay. And perhaps being consciously competent is a minority sport.

The Johari window is a two by two grid where the four windows comprise: unconscious incompetence, conscious incompetence, conscious competence and unconscious competence. These states refer to potential learners. The unconscious competence described here by Dr R is not necessarily a bad thing. It might refer to learned principles that have become internalised and instinctive. It might equally refer to competent behaviours that have arisen without any formal educational input. Dr B illustrated a successfully intuitive ethical reflection by his colleague, emphasising that this would be unlikely to involve philosophical jargon.

Dr B: So, so my partner, with his very intuitive style – I think if you said to him, 'Tell me about your ethical reflection on X,' he would burst out laughing and kick you out of the room. However, there most clearly is an ethical reflection on X. One can tell that because of the answers he comes out with, the way he deals with people. But his ethical reflection on X is quite intuitive.

Among the general practitioners involved in teaching medical ethics there was a conscious awareness of how ethical considerations might become 'hidden'.

Dr M: [Soren Holm] very much emphasises that thing of awareness of issues and also how people can get into automaticity -they can routinise certain procedures, which then makes them unaware that there are ethical issues involved.

This 'routinization', coupled with a loss of conscious awareness of the ethical issues implicit in a transaction or procedure may represent a form of unconscious competence. In informal conversations off recorder, some of the participants mused about whether the initial panic that some GPs perceived in response to an ethical issue was equivalent to the transition from unconscious incompetence, to conscious incompetence. This might be represented by the ability to recognise an ethical issue but not necessarily be confident in understanding and dealing with it.

Embedded ethics and unconscious incompetence

The authors of the RCGP curriculum guide also offer cautionary advice about the failure to reflect (page 115, quoted below) under the subheading of 'justifying and clarifying personal ethics.'

Riley et al: A person's espoused values and their real-life behaviour can often differ... If you don't take time to reflect on your actions when ethical issues arise in practice, you may not be aware if your behaviour starts to deviate from the values you support.

This view of the normative value in firstly learning to reflect on values and ethics and secondly re-analysing issues as they occur throughout professional life was reflected in my data. Professor A, an Australian GP involved in commissioning educational products for GPs, described unconscious incompetence in older practitioners, using the analogy of a (morally) good boiled egg:

Professor A: If you think about, so we've had an egg that's raw, one that's a bit cooked, and we've had a boiled egg. Now we've got a hardboiled egg that's been in the fridge too long. And when you cut it in half, you see there's black rings which tell you the egg's old. And that's the thing that happens to practitioners who don't think about this. They get black rings. And they

are fixed on those rings, and they demarcate any possibility of change. So, you can get practitioners who are then, say they've got like Jesus, the way of the truth and the light, and stick by it. And so they become, where they might have been unconsciously competent, they become unconsciously incompetent again, because they don't know what things have changed and how the world and society has changed. And they are reflecting back on something that was hardened and worked for quite some time, which doesn't work now.

Professor A's comment is different from Riley et al's views. Whilst Riley et al caution that an unexamined set of moral beliefs may be too flexible, and risk a loss of moral integrity, Professor A highlights problems with moral beliefs that are too rigid and inflexible. On the one hand a 'hard boiled' GP may embody the values that he espouses. On the other he may have attitudes which do not sufficiently adapt to new ideas or societal change during his career.

Consciously engaging with ethics in practice

Above, Dr R suggested that being consciously competent in the application of ethical knowledge to practice was a kind of minority sport. Participants described the phenomena of deferring to rules and guidelines as well as to more expert or senior colleagues, but they also described thinking through ethical problems. Dr B suggested that it might be that ethical reflection using academic tools and vocabulary was the minority sport.

Dr B: I'm not sure that I see ethical reflection as a minority sport. I see particular academic forms of ethical reflections as a minority sport.

Some participants did profess the use of their academic expertise in practice. Dr S (for example) suggested that his consultations were better as a result of having ethics skills. He had achieved some expertise in the subject and his colleagues accordingly used him as a resource. In effect he became someone whom others deferred to.

Other participants also discussed the benefits of being able to think through an issue or understand the ethical basis of rules and guidelines. According to Dr L, the right role for ethics education is to give professionals the education to understand their own ethical boundaries and theoretical tools with which to critique their own decisions. She illustrated this by reference to a module on a Masters degree aimed primarily at GPs.

Dr L: ... I believe the objective of the module is how, is not to produce experts at the end of it, but to get those people taking the module to have a better understanding of how, you know, to kind of think about how an understanding of ethics and kind of professionalism can all kind of maybe clarify how they think and how they view things and how they can resolve them.

The ability to consciously think through a problem rather than defer it conveyed a benefit in terms of emotional well-being. Dr D described her relief in understanding that being beneficent to her patients regardless of conflicting duties and opportunity-costs is unrealistic.

Dr D: whereas after that one and a half hours' lecture, realised, you know, if you're an alcoholic, I can't give you a liver, no matter how much I like you as a person, if you're not going to stop drinking, why should I give you that liver when someone else needs it? It kind of clarified things and took a bit of the burden off me, feeling like, 'Oh I've got to help everyone.'

For Dr D in the particular instance above, the application of Beauchamp and Childress' four principles of Bioethics unburdened her. Rather than pursuing simultaneously trying to follow conflicting duties, she was able to see that these might be weighed in the balance.

There were benefits to possessing ethical expertise and possessing sufficient competence to cope with complex and uncomfortable situations that arise in practice. However, there was also a sense that how far a GP used theoretical tools to understand the ethics of ordinary, everyday practice was down to individual learning and practicing style:

Dr B: I think it's hugely different for different GPs. And, as I say, I couldn't answer that question without again referring to sort of personal styles. To some extent, learning styles, but also, I think there are practicing styles. So my style is actually quite, I actually need to literally work things through...

Dr B said that trainees also needed to go through a phase of working things through before developing a more intuitive style. The ability to use ethical theory to analyse practice in a conscious and deliberate way was not always seen as necessary. However it is arguably a useful skill for the purpose of ensuring that trainees are sufficiently competent.

If a GP is aware of ethical complexity and conflicting duties then this can make the daily work of practice more laborious. Participants with some experience of both practice and education were keen to point out that this did not mean that an ethical approach should be avoided.

Dr S: And in a sense it's made consultations more complicated, being aware of [ethical issues].

Professor Z illustrated the idea that an ethical commitment to respecting patient autonomy took place in the face of a lack of support from colleagues, particularly because it takes time to fully inform patients of their options.

Prof Z: I'm a great one for respect for patients' autonomy, though always pointing out that such respect has to be compatible with equal respect for the autonomy of all potentially affected and so on. But nonetheless I was pretty reluctant to be paternalistic in the sense of knowing what's better for the patient. So I used to, you know, discuss these issues quite a bit with patients. And I think my partners thought I was a bit of a nutter in this respect ... They just felt that I, you know, that I could just get on with saying, you know, what they ought to have in the way of treatment in the same way that other doctors did, rather than discuss the alternatives and pros and cons.

According to Prof Z, his colleagues objected on the basis that fully respecting patient's autonomy took time, and this was time that could be better spent seeing more patients and doing more work. The lack of time for ethics in both education and practice was raised as an issue by many participants. It is one of many systemic barriers to reflective practice.

Conclusion

The manner in which ethical issues are identified, and the strategies for engaging with ethical issues appear to be enacted in a more complex manner than the phases of ethical competence to which I referred in the introduction to this chapter (Hamric and Delgado, 2009).

Participants' accounts echo some of the educational materials for GP-trainees and medical students (Gillies, 2009, Hope et al., 2008) in that they suggest that both intellectual tools and more intuitive or emotional approaches are used and indeed useful for identifying and managing the ethical content of general practice. However, it is difficult to make an authoritative statement of where the emphasis should lie, for example whether emotions should be guided by reason or reason tempered by emotion. Professional etiquette, academic

ethics, emotion, intuition and other ways of approaching ethics are all potentially inadequate in isolation from one another.

Participants displayed and described not just an array of ethical strategies but also personal styles. Such styles might be shaped by personality or social background as well as educational experiences in medicine and general practice. Postgraduate education materials for GPs acknowledge the idea that individuals may have individual learning styles. However participants associated ethics education predominantly with undergraduate education (see chapter 5) so it is possible that ethics education does not benefit as much from this flexibility of attitude to learning.

The idea of competence described in terms of unconscious incompetence, conscious incompetence, conscious competence and unconscious competence applies to ethics as any other skill. Using these four ways of describing competence is present in multiple learning materials for GPs (Riley et al., 2007b, Naidoo and Davy, 2005). Forums that look at difficulties in the doctor-patient relationship, and mentoring relationships such as that seen between GP trainer and GP-trainee may assist with the identification of unconscious incompetence. This is because they are educational settings and may be perceived to be safer settings in which to display ethical ignorance. Unconscious competence can look like unreflective practice and all too easily may become unconscious incompetence in the face of new cultural or technological developments.

The participant data also suggest that as well as strategies and styles, other factors may shape the manifestation of ethical competence. However competent GPs may appear in managing situations that have ethical content, there are external factors that limit how well they are able to engage with an issue or seek some form of support. The availability of time to pause and consider, or time to reflect, may influence whether a GP avoids an ethically complex encounter, defers to others' guidance or engages more fully with the issues at hand. A fear of

criticism represents the flipside of the drive towards excellence, and this is also relevant to life-long learners and educators. It seems that the lack of time for ethical reflection due to more pressing priorities is compounded by the idea that any kind of explicit engagement with ethics might carry sufficient salience as to be considered professionally risky.

Chapter 8: Substantive ethical issues encountered in General Practice

(Part 1)

Introduction

In previous chapters I have discussed *how* GPs identify and engage with ethical content in what I treated as the distinct contexts of formation, evaluation and practice. By contrast this chapter and the next one are about *what* it was that the participants identified, *what* was visible as an ethical issue requiring awareness and consideration. These chapters do not aim to establish a verdict on the rightness or wrongness of any one position on any one substantive issue. Neither do I seek to establish an exhaustive list of issues identified by participants. I do, however seek to demonstrate the messy complexity that distinguishes the clinic from the classroom and the academic assessment room, and extract insights of relevance to the ethics education of GPs. I do this by selecting four key issues that were discussed more frequently amongst or more extensively by participants and by considering them in light of the approaches to ethics which I identified in the preceding chapter. This chapter focuses upon two issues in professional ethics closely related to the personal relationships between GPs and their patients – confidentiality and abortion. The following chapter considers two issues that highlight both the financial and the socially embedded and governed nature of GPs work – financial incentives and rationing. In addition to reviewing the ‘content’ of ethics, and the

multi-faceted nature of the issues GPs need to manage, I conclude the chapters with some brief reflections on the implications of each theme for ethics education. These implications then feed into Chapter 10, the conclusion, in which I further develop my reflections on the implications of my findings.

Confidentiality

The problem of respecting confidentiality was a frequently occurring ethical topic in my discussions with participants at all levels of experience. It represented the strongest substantive issue emerging from my data. This may be because it is a visible topic for ethics education and often a visible issue in practice. Confidentiality may also be a safer topic to discuss in relation to practice. Other topics such as assisted suicide and euthanasia may carry more of a perceived risk of being reported to the professional regulator or the police if discussed in the same way. Regardless of whether GPs find other issues more problematic but are afraid to discuss them, there is evidence that doctors find confidentiality problematic enough to contact their trade union for ethical advice (BMA, 2010). In the section on confidentiality I discuss how confidentiality issues were recognised, and use the participants' encounters with confidentiality to illustrate key issues of relevance to ethics education.

Recognising confidentiality as an ethical issue

In the previous chapter I discussed the idea that certain issues are pre-labelled as ethical, for example in professional literature and educational materials. Confidentiality is prominent amongst the General Medical Council's 'Duties of a doctor', and confidentiality has been identified in the general practice literature as a core feature of general practice (Slowther,

2010, Pereira-Gray, 2010). It was also perceived as one of the 'big ethical issues' in general practice by more experienced GPs such as Dr M and Dr R. Confidentiality represented a clear example of an ethical issue of particular concern to younger and less experienced GPs, as Dr Q and Dr H illustrate below.

AP: What would make you think, "I need to think about this problem in an ethical way?" What kind of problem would make you think like that?

Dr Q: Usually it's something that involves ... some principle like confidentiality rather than a medical problem like, "This gentleman had a rash, we treated it with this..."

AP (addressing a group of GP-trainees): What kinds of situations prior to today would you have thought about when you heard the phrase, 'ethical issues in general practice'?

Dr H: Confidentiality - Whether or not to disclose.

It is not surprising that the GPs whom I spoke to identified confidentiality as the key ethical issue in practice. For UK GPs, a duty to respect confidentiality is very prominently displayed in the metaphorical shop window. The UK General Medical Council asserts that 'Patients have a right to expect that information about them will be held in confidence by their doctors,' and 'Confidentiality is central to trust between doctors and patients.' (Slowther, 2010, GMC, 2009). The legal basis has been described as a public interest duty, and is protected by both the Data Protection Act 1998 and (via the Human Rights Act) article 8 of the European Convention on Human Rights which confers the right to privacy.

A key reason that confidentiality is recognised as an ethical issue, therefore, is because it has been identified as such by the profession and those who set the curriculum for it. Circumstances where respecting confidentiality may be problematic are included in learning materials at all stages of GP-training, such as in this quotation from the same study guide.

The commonest difficulties in general practice concern driving e.g. newly diagnosed epileptic.
(Mead, 1995).

This often-used example represents a clear conflict with clear duties. At face-value it has limited educational value because it has a clear answer. The GP has a duty to record and (if the patient will not) disclose the patient's health status to appropriate authority, but only if he or she thinks that the patient will drive if this is not considered medically safe. However there is a more profound point to be made, which Slowther touches on in an article on confidentiality aimed at GP-trainees.

GPs... are more likely to be aware of the social dimension of their patients' lives, for example, to know if their patient with epilepsy is driving... (Slowther, 2010)

GPs are generally based in a community setting, with access to a complete healthcare record, often look after entire families, and have the potential to see the same patient many times over many years. There is consequently more scope for GPs to encounter situations where confidentiality becomes problematic than in many specialist settings.

Confidentiality as an invisible issue

Despite confidentiality being such a visible topic, I was told that it could be overlooked in practice. For example, the issue of confidentiality between family members is not an immediately obvious one for all trainees. Dr R (for example) observed a lack of sensitivity to confidentiality in GP-trainees.

Dr R: They really don't see a problem about certain things, particularly issues about confidentiality in relation to the relatives, for example, sometimes ... And I've had some quite – quite worrying cases ... I remember one trainee that was actually fairly near his, his – the end of his training. And I was supervising him and I was looking through his notes, and I thought, 'Gosh there's an issue, a confidentiality issue here and he hasn't seen it.'

In theory, confidentiality may not arise as an issue because of a presumption about fact, for example that relatives are already privy to a patient's health information or that the patient consents to the information being shared. The invisibility of confidentiality may also however result from an assumption that relatives ought to know the information. In the subsections below, I give three examples of confidentiality issues that can become hidden.

Confidentiality and family

The idea that family members legitimately might need to know a patient's information was seen as relatively uncontroversial. Such a view was possibly hinted at by Dr Q in the scenario below.

Dr Q: ...let me give you an example that we have, and I sort of have an issue about. On a regular basis we have a hostel that we provide a medical service for which is mainly a sort of stop house for rehabilitating alcoholics, and the managers, who are two very nice people, who are not medically trained, sort of run the shop and I seem to convey a lot of medical information to them, about medication, whether they [the patients] should be having medication, and why I think I'll reduce this dose or increase this dose. And they're not family, they're not relatives, they're just 'like' the hostel care workers, and it's a question of –they're very responsible people and very good and I've met them on a number of occasions- but the question is, should I be divulging that

much information about these people? And do they [the patients] always know that I'm talking to them [the care workers] about them?

Dr Q was uneasy about whether he should be divulging confidential information to people he perceived as informal carers. He perceived no professional (not medically trained), or familial (not relatives) entitlement by the carers to access confidential data. An immediate question that arises is whether some GPs might presume that relatives and medically qualified carers should have automatic access to confidential information.

The expectation by relatives that they should be entitled to access a patient's healthcare record is an ever-present issue in general practice. A common example of this is where children have an interest in keeping details confidential from their parents. However in other cultures there may be a broader expectation by relatives of access to healthcare records. Dr N referred to the widespread practice in Russia of telling the nearest relative but not the patient of a diagnosis of cancer (field notes). She reflected that it might possibly be an issue among some immigrant families to the UK in dealing with UK trained GPs (field notes). GPs who encounter an expectation of access by relatives may inappropriately acquiesce or inappropriately withhold information.

Confidentiality and healthcare colleagues

The idea that medical colleagues and enclosed medical groups are automatically confidential is also problematic. Implicit in Dr Q's account (above) was that medically trained individuals might have some entitlement to view confidential patient information. Perhaps some doctors might expect colleagues to automatically keep confidences – for example, Dr O wistfully

recalled that he could discuss patients with colleagues in the protected environment of hospital medicine:

Dr O: ...if I was in the hospital I could, you know, in the junior doctors' digs or in the Mess or whatever, I could speak freely. That's not possible [now in general practice].

For Dr O there was a presumption that doctors would keep the details of a case being discussed to themselves. Confidentiality was contained within the walls of the doctors' mess. Dr O felt that educational and moral support might still be more safely obtained from colleagues.

Dr O: And also there's a group of local GPs that meet sort of semi socially that I would be free to bring such matters to if it could wait. Again, issues of confidentiality although one has to be less careful about that because they're all GPs, but nevertheless it's an issue because they're all local.

Dr O's perception of GP colleagues as safe discussion partners reflects educational materials that suggest that confidentiality is maintained provided that information is kept among those who understand confidentiality.

You can of course discuss matters with your [GP] partners and other members of the health care team but anyone to whom confidential information is given must also appreciate the ethics of confidentiality (Mead, 1995).

Mead's advice above is in line with the idea that the immediate healthcare team are likely to require information in order to contribute to the ongoing care of a patient.

Where a GP or a member of practice staff was a member of the community in which the GP surgery is situated, issues of confidentiality surfaced. The possibility of disclosure to someone unauthorised and its consequences was more important than any principle in discussions with participants. Dr O illustrates this by reference to an online discussion group:

Dr O: ... at the [annual RCGP] conference, I met some guy... who's setting up an Internet site ... that's all about if you've got a query you post it on his website and anyone who logs into the website will give you an answer. And that seemed like a good idea when he sold it to me at conference. I was going to support him. But actually, every time I've sort of thought putting anything on there, actually I realise immediately there was a, there could be problems of confidentiality. You know, I've just had a clinical dilemma, someone's just come to me, and I've posted it on his website. What happens if that same patient goes on to the Internet, not an unlikely scenario, searches – Googles the problem that he's got and up pops my question on Med Crowd. I mean I can imagine that that might make the patient not feel very comfortable and feel very cross with me.

Dr O's description of the patient's anger and discomfort that their secrets are being discussed echoes the view (Pereira-Gray, 2010) that patients are happy when doctors espouse a strict respect for confidentiality.

Sharing potentially confidential details with colleagues was described by participants in the following ways: direct assistance in making a decision (most participants), the GP seeking to be educated or educate others (most participants), emotional support (Dr O) and 'banter' (Dr Q). The only controversial aspect of all of these that participants raised in discussion was the possibility of the patient finding out, or harm resulting to the patient from the disclosure of confidential information. This perceived possibility of discovery or harm was very much linked to the social closeness between health-care professional and patient, whether it was geographical or via the internet. Without appreciation that such proximity might generate an adverse outcome, there is the possibility that sharing inappropriately with colleagues may be invisible as an ethical concern.

Keeping information from patients

One issue that is potentially hidden is when a GP is given information about a patient and asked not to share it with the patient. None of the participants talked about the situation where a friend or relative gives information about a patient but does not want to be identified and/or does not want the patient to know that this information has been disclosed. However Dr Q questioned whether a patient should be entitled to a copy of a consultant letter if it is not copied to the patient.

Dr Q: Even silly things like I had a patient who came in to me, and this is another good example, and I wasn't sure of the answer to that. A consultant had written to me and it was addressed to me regarding this patient. It said 'Dear Dr Q thanks for referring this patient blah blah blah...' and the patient said, "Can I have a copy of that letter?" And I wasn't sure what to do. And I said –my answer was, "Listen it was actually addressed to me I shouldn't really be giving this to you." Now it is about her and wasn't really sure about whether I give her that letter or not give her that letter. Because it's addressed to me. Again I'm not quite sure where we stand with that. Can we? can't we? Is that information strictly between the two clinicians or is the patient allowed to see that? Was what I did ethically right or wrong? Was I wrong? Is that an ethical problem or is it just a management problem?

It is difficult to justify correspondence between clinicians that the patient may not access. The usual justification is 'therapeutic privilege', where it is claimed that the information will harm the patient in some significant way (Johnston and Holt, 2006). Whilst it is unlikely that the letter contained information which would be significantly detrimental to the patient's physical or mental health, there was no indication from Dr Q that the letter had been copied to the patient.

Whilst this might represent a simple ethical learning need on Dr Q's part, the scenario illustrated a potential weakness in what has been called preventative ethics. In this case the way of preventing the ethical question of whether details should be shared with the patient is to ensure patients have access to their correspondence at the outset. Thus it is common practice for patients to be copied into correspondence between doctors (and some would argue that consultants' letters should be addressed to the patient and copied in to the GP). If the letter is copied to the patient, then there is little doubt that the patient is entitled to its contents. However, a widespread policy of copying in patients not only solves the problem but removes it from view. So when a patient is not copied-in (deliberately or as an oversight) this could in some circumstances result in worse confusion on the part of the GP.

Confidentiality and guidelines

Respect for confidentiality is enshrined in both law and professional guidance. Consequently the strategies for dealing with confidentiality largely revolved around professional duties and their codification in ethical guidelines. For example, Dr Q described a set of guidance booklets provided by the General Medical Council which doctors receive on qualification.

Confidentiality, notably, is foremost among them.

Dr Q: ...those little books that they did there were four or five of them: Confidentiality, data collection, and all that sort of thing...

General guidance on confidentiality is made available to all doctors. However, participants complained that they were unfamiliar with guidance, and that the guidance was not clear or specific enough. Nuanced approaches to ethical guidelines on confidentiality encompassed wider ethical skills than rule-following. Moreover, even when there was a reason for

confidential details that guidelines envisaged, there was ethical discomfort based on genuine ethical concerns.

Is ethical guidance unfamiliar or not specific enough?

I encountered anxiety among participants that they did not have specific guidance for the circumstances when they found confidentiality problematic.

Dr D: ... I don't have this experience, I haven't been trained in it, nothing ... I don't even know the rules and regulations.

Knowledge about ethics law and professional guidelines appeared to be a perceived need.

Dr Q: The ethics... I think it's almost assumed that you know all of this... You know the ethics and confidentiality... which is not necessarily true.

Dr Q, for example, was unaware of specific guidance that authorised him to talk to people who were not related to patients nor part of the practice healthcare team but who nonetheless assisted with the care of patients. This made him wonder if he might be practicing unprofessionally or even illegally.

Dr Q: ...am I breaking the law of confidentiality or am I doing something that I shouldn't be doing, inadvertently? So like, as I said, talking to this, talking to the care workers, am I breaking confidentiality or am I, is it OK because I'm looking out for the welfare of the person? Where is that line drawn? What is right and what is wrong there? Because at the end of the day I am technically looking after the welfare of the patient, but am I going about it in the right way? Am I? I don't know. There's no book that says you can speak to a hostel care worker regarding this patient...

Dr Q felt that what he was doing was right because it aimed at improving the welfare of his patients, but was not confident that he was following the rules in an acceptable manner.

Dr Q's desire to follow guidelines manifested in the desire to know the correct procedures to follow to ensure that legal and professional duties were met. He suggested a number of procedural aspects to safeguarding patient information.

Dr Q: Do we need to make sure it's them –get some ID from them? Sometimes we may have seen the patient for the very first time –I don't know who they are ... We do a lot of telephone consultations: Am I speaking to the right person? Am I giving them too much information? Am I giving them not enough information? You knowif you did have to give information to a patient, what you needed to do so you did correctly provide that information. Was there any forms you needed to fill in blah blah blah etc etc. Like when we do an operation we sign the consent form. We'd need to do that.

Ethics education potentially concentrates on principle rather than procedure. Consequently, GPs may have difficulties in knowing when procedures should be followed and when they are inappropriate. This requires an understanding of what principles underlie those procedures and guidelines, rather than learning an ever fatter book of rules.

Nuanced approaches to confidentiality

Some educational advice can appear extreme. The quotation below, from a GP study-guide (Mead, 1995) emphasised the strict adherence to confidentiality and the procedural step of written consent.

Consultations between GP and patient should be strictly confidential. Disclosure of confidential information by the GP is a serious breach of ethics... Only rarely will disclosure be judged to be in

the public interest – consult your defence society before any disclosure to a third party without written consent from the patient.

Dr Q was unsure about whether it was necessary to obtain written consent from patients in order to share their details with carers.

Dr Q: Should I go through a formal process of getting them to get the patients to sign a consent form to say that they can divulge this information to these people, or you know, the system's OK and everything's running fine and no one's complaining and the information is getting through to people and err... everything's ok.

Above, I mentioned that the exact setting for Dr Q's comment was where the managers of a hostel for recovering substance misusers were requesting information pertinent to his patients' care. Nothing had yet gone wrong and no one had complained. Sharing the information allowed the managers to help his patients get to their appointments and take their medications appropriately.

The idea of adhering to prima facie rules sometimes being easier than making a rational exception was illustrated by Dr C, talking about people telephoning to discuss elderly relatives.

Dr C: And I guess, I mean the easiest thing to say is, 'I'm sorry, I can't discuss anything about your mother because she hasn't given me consent to discuss her health with you.' And sometimes you've got to do that if you're uncertain of the situation.

Participants' accounts of dealing with information requests by family members and carers illustrate the ability of GP s to be ethically nuanced, rather than simplistic, in the interpretation of guidelines. This kind of issue is a recognised source of ethical tension and finds its way into both educational and evaluation context. Dr E used confidentiality as a way of distinguishing a nuanced ethic from a rigid adherence to guideline.

Dr E: I think that you can be a doctor who is so concerned about ethical sort of dotting the 'I's and 'T's that they do not behave in a professional manner. And the example that I come back to is [where medical students] form a confrontative position with the patient and say, 'I can't tell you anything, medical confidentiality.' And the rest of the consultation is, is stonewalling and not, not really engaging with the patient at all. And I think that's utterly unprofessional, though ethically the GMC and MDU may be very pleased with that candidate and I'm not.

A potential danger of the desire for a definitive guideline is that students, trainees and doctors will adhere to a prima facie duty even when this not the right thing to do. In the quotation below, Dr E illustrates how this arose in the older version of the RCGP membership examination (However, this could just as easily find its way into the newer MRCGP examination).

Dr E: ...it would be that, you know, 'Mrs Brown's booked in to see you and when she comes in, they ask you whether her mother has been drinking,' and I mean clearly what one is looking for there is not just an understanding of the ethical principle, that breach of confidentiality is a serious issues of medical malpractice, and you need to be aware that that's the sort of scenario that you may do it. But it's more I think in, in – that is a key issue, but in addition in a membership exam, one is looking, not for someone to make a cold brutal statement to the patient, but 'I'm sorry, that's totally inappropriate, we can't do that because medical confidentiality means I can't tell you anything,' one would look to see whether the candidate was engaging the person being polite to them seeking to understand their viewpoint and to be as helpful as they can.

The notion of 'total confidentiality' is an erroneous one which I encounter when I hear medical students reassure simulated patients that anything they say will remain solely between them and the patient before they have heard what the patient has to say. This may represent either a false promise or one which may be kept inappropriately.

In the quotation below Dr C illustrated a nuanced approach to confidentiality between relatives.

Dr C: Quite a common one is a son or a daughter ringing up and asking to speak to me or another GP about an elderly parent, for example. And often – we’ve quite an elderly population, and people move away because of, they move away to find work. ...a son or a daughter, whom I’ve never met, might ring up about say, her mother who’s failing. And needs some support. And ask, ‘What’s wrong with my mother?’ And she might, ‘Why can’t you get her more support?’ Or, ‘How is she?’ or whatever. So that’s often really the issue of confidentiality. And these are quite difficult sometimes, because I guess the way I would respond there is – I find it’s often based on my judgement of, my knowledge of the elderly person, what he or she would like, and what I can pick up from the relative who’s ringing ... Sometimes you can make a judgement based on their understanding of the nature of the person you’re talking about, which is sometimes a bit risky. But that can sometimes be helpful, that can sometimes be in the best interests of the patient as well, particularly if an elderly person is in failing mental health and not quite sure about her mental capacity.

The risk to which Dr C refers could be professional risk (of a complaint that confidentiality was breached) or risk of causing harm to the patient in some way (also wrong). Dr C exercised judgement of what the patient might be likely to want (in the absence of valid consent) but also made a judgement about patient benefit. An understanding of concepts such as confidentiality and best interests was a prerequisite for such a conscious nuanced judgement. Dr C did not report checking each and every such decision with an indemnifier, or seeking written consent. In the case of a patient with dementia or a mental health problem it may not be possible to secure legally valid written consent from the patient.

Dr O, a much younger GP looking after a semi-rural population, was also prepared to exercise some judgement but only where he was confident about what a person would want.

Dr O: I usually go out and seek their explicit consent, unless I have good reason to think that they would, you know, or that they wouldn't be agreeable to sharing the information.

Discomfort about justified breaches of confidentiality

If sticking to a prima facie set of rules is easy, then breaking or bending them can be hard, especially if a judgement has to be made in practice, and even more so if the GP can expect their decisions to be scrutinised and questioned at a later date. An understanding of the circumstances when there could be an exception to confidentiality was a key concern for Dr F.

Dr F: ...it's the whole confidentiality sort of thing. And when it's to be broken, which I think is quite hard actually.

Professional guidance is clear that doctors are permitted and may even have a duty to share confidential healthcare records:

1. When the patient consents to the information being shared
2. When others may be at risk of serious harm
3. When it is required by law

When others are at risk of serious harm or when a doctor has a legal duty to disclose confidential information, doctors are encouraged to disclose where possible with the patient's

assent but assent is not essential. Ethical discomfort may arise even when each of the conditions of disclosure above (including with consent) is clearly satisfied. Participants in the study offered examples of all three types of justified disclosure that were difficult.

When the patient consents

When a patient consents to a GP sharing confidential details with someone else, the GP may perceive ethical discomfort. This can flow from the nature of the information and the potential for it to cause harm. Dr H, a GP-trainee, presented the following case.

Dr H: I had a 15 year old girl, just come over from Somalia the week before, living with her dad who had been here for about a year or so, and in a very overcrowded house ... -Came with abdominal pain and nausea, vomiting, a bit of pyrexia. -Couldn't speak English so I had to get an interpreter on the phone. And dad came spoke a little bit more English than her. I got a bit of history, told dad to go to the waiting room, asked if the girl could answer some more questions and he said, 'Yes,' and I asked her about her periods. I had a chat and found out that she was pregnant, and she was married to somebody without anyone knowing, when in Somalia ... And I was getting a bit worried about her safety, because if her dad knew – if she was pregnant and she was married without anyone knowing. And now confidentiality [was an issue] because she had presented here. Her dad was waiting in the waiting room and he would come to ask me what had happened to her. I didn't know what to do that time, if I could tell dad ... And she said, 'Can you please tell my dad that I'm pregnant and this is what happened?'

Implicit in these details is the idea that the daughter had a right to privacy. Dr H described a professional approach to respecting the patient's confidentiality via use of an interpreter on the telephone, and inviting the father in for some but not all of the consultation. The patient absolved Dr H of her duty to keep her secret pregnancy, by asking that she tell the father.

However there was still a residual discomfort and uncertainty as to the right thing to do. Dr H explains why below.

Dr H: ... I was worried why she asked *me* to tell her dad, what the implications when she went home, whether she would be cast out or not, or whether she would have – if there would be some kind of repercussions at home. That's why I was worried why she was asking me to tell dad.

It seemed clear at the time that I spoke to Dr H that she was chiefly concerned about harm resulting from the information disclosed. If anything the request (as a doctor) to facilitate the disclosure made her worried that she was being asked as an authority figure, and to protect the daughter from repercussions.

A far more common way in which people routinely ask GPs to divulge confidential information on their behalf is where the information is required for insurance or occupational health. Dr R, an experienced GP with expertise in ethics and professional guidance regarding healthcare records, illustrates this in the quotation below.

Dr R: ... I had one this week. One of these occupational fitness things. And she'd ticked 'no' to mental health, the mental health section, which was fairly broad, the questions, you know, psychosis, mental illness, psychological problems, distress. And in fact she'd been seen, on a couple of occasions, with stress related insomnia. And she'd had a course of hypnotics and it had all settled down quite quickly. So it wasn't serious and it wasn't relevant to her fitness, but nevertheless I was concerned that I couldn't say she hadn't had anything. And she ticked the 'no' box. *So I just used my algorithm*, as you say, my view, and I got her in and talked about it, and said 'This is how they, this is how I think you have to interpret what they've said,' and it was as I thought. Not that she was lying,... or particularly consciously concealing, but she thought, 'Oh well I don't think that really counts.' There was a certain amount of hoping that it doesn't count, 'because they might not like me if I disclose it.'

This case involved the benefits and harms of including and excluding certain pieces of information in documentation, set against a professional duty of complete disclosure. Dr R had sufficient knowledge and experience to recognise that his duty of truthful disclosure was unlikely to cause significant harm and so this was not a source of discomfort. He did, however recognise that the patient might have an interest in withholding information, even though she had given consent to his providing a full and honest report.

When others may be at risk of serious harm

Dr N discussed a case where professional duty permitted and moral duty required disclosure of sensitive information [field notes]. A man, who had contracted a treatable sexually transmitted illness (STI), wanted his pregnant partner tested for it without her knowing. Testing for STIs can be a routine part of pregnancy screening. However, the pregnant woman can refuse to be tested, and Dr N reflected that the partner is not automatically entitled to the results (which he had also requested). If the pregnant woman required treatment she would need to know why she was being treated. This was likely to involve breaching the man's confidentiality.

Dr N's case was potentially clear-cut because there is a risk of harm (untreated STI) to both the woman and her pregnancy, and in this case deception in terms of testing and treatment is practically difficult and professionally forbidden. Talking to Dr N it was clear that she felt that disclosure to the pregnant woman was the right thing to do. Her perception of difficulty was less moral and more professional – that the man might complain about her if she violated his right to privacy.

Dr D presented a less clear case. The case she presents below arises out of the familiarity and trust that can be established in the relative intimacy of the GP consultation, where, for example there is a closed door, and the patient may have seen the doctor more than once.

Dr D: A patient [presenting with a history of minor illness] suddenly just said, 'Doctor I feel comfortable with you, can I say something?' And I said, 'Yes, what is it?' And he went, 'I have urges.' And I was like, 'Oh okay, what urges?' 'I like little children.' I had a total blank look straightaway, you know, I was just, 'Oh God. I don't want to be here.' ...And I said, 'Girls, boys?' And he said, 'Both.' And I [checked his record], and I saw he has little children. And I said, 'How would you like me to help you?' And he said, 'Oh forget it. Now I'm fine... Oh... cough... Yes fine.' And just said 'Okay, 'bye,' and walked off ... And I was just sitting there thinking, 'Now what do I do?' I mean who do I refer him [to]? And if I do refer him, will they, do I have to tell the authorities what's going on here?' ... Do I inform some authority and find out what he works as and all that, if he's working with school children, do I, you know, if he's a teacher or something, is it my job?

The key factors Dr D considered important in deciding whether to preserve her patient's confidentiality were in effect two sets of risk factors: risk of harm from disclosure (harm to her patient), and risk of harm from non-disclosure (to children).

Dr D: ...this man, I don't know whether he's acted upon his urges or not... And when someone asks you for help, I don't want the person to feel, 'Well I asked you for help and you penalised me for that.' ... This is much deeper, because society really hates paedophiles. Okay, and for that, and then I was thinking, if he's acted upon his urges, am I going to act differently? And if he hasn't... I knew what I would do, I would give him all the support and keep it quiet, to help him improve or whatever. ... Is there any counsellor who will counsel him, without telling the authorities? ...But then I'm also concerned about the children. So when you put the ethical thing

in, straightaway you will inform social services and everyone. But then am I doing more harm if he's not harming his children...

For Dr D, her primary duty was to 'help' her patient and the duties to unknown people were the source of conflict. Dr D went so far as to refrain from immediately including the conversation in the notes.

Dr D: If I write that in his notes, and it was all nothing, and if my partner decides not to do anything about it ... everyone can see it. You know, someone, the receptionist printing his repeats or something like that ... if he says, 'Oh I want to see the doctor,' they put his name in and just say they do go into his notes, they will see that, and I don't want them to know about this ... And some of them do live where he lives ... And like this man, if it just comes out like that ... also I'm just wondering how much of it, because it's in the news about paedophiles, children, blah, blah, blah ... Okay, maybe he is a paedophile in the making or something. I don't want to destroy someone.

Dr D began her reply to my question by avoiding the issue. The patient had presented with a cough and therefore that was what belonged in the notes. She asked aloud if following up on this disclosure was her job. However she had the moral courage to explore why she felt uncomfortable, and why she might not include a record of the confession in the patient's notes. Her key reason was not a desire to avoid criticism down the line but a concern about the security of the information that she might enter in the patient's healthcare record. The possible repercussion was that someone with less of a professional commitment to confidentiality, or with a greater interest in making the information known might see the information. This concern about who can see the notes on the computer screen is reflected in the educational literature (Slowther, 2010).

When the law required that confidentiality be breached

Another way in which confidentiality illustrates the differences in levels of ethical experience is where confidential records are disclosed to the police. I have already discussed two contrasting examples of this phenomenon in the previous chapter. In both cases (Dr B and Dr O) there was no real doubt in the GP's mind. A duty to protect the public from harm (Dr B) and to detect serious crime (Dr O) overrode the duty to keep healthcare information confidential. Despite being sure about the right thing to do in this case, both doctors called their respective medical indemnity organisations. In both cases it appears evident that this was for legal and professional validation (see previous chapter). Dr O illustrates how, in the absence of support from the indemnity organisation, he temporarily lost confidence in the rightness of his decision.

Dr O: ... And I rang the MPS and the lawyer I spoke to gave me... very confusing advice. I really thought it was really straightforward, you know, okay this is a serious crime, no question of argument, just open up the file and let them see what they want... But the solicitor from the MPS [this would have been a medicolegal advisor not a solicitor], I don't know, seemed to be playing devil's advocate or something and made me very confused, so much so that I refused to open the file for the police. I said they could have it, but with all the bits you're interested in redacted. Anyhow, they came round again because this was a very serious crime. And someone said to me that legal proceedings were going slowly and painfully and I thought, well you know, I'm going to revisit this. So I rang MPS again and I got much clearer advice, much more in line with my original felt position. And the advice was that: if the police were there then show them the file. And I have to say it resulted in a conviction.

By contrast, Dr B gave the impression that he would have been surprised had the medicolegal opinion differed with his view, because he was confident that his ethical, professional and legal duties were in alignment.

Dr B: And therefore that was a very good case where it would be both ethically and legally justified, and regulations wise, justified, GMC wise, to breach confidentiality... So that was an example where I broke confidentiality, being actually very confident that it was ethically the right thing to do, legally the right thing to do and regulation-wise the right thing to do.

Abortion

The recognition of abortion as an ethical issue

Abortion pre-recognised as ethical

There is a vast academic and educational literature on the ethics of abortion. While and Attwood list requests for termination of pregnancy among the identified ethically problematic issues with which GPs may have to contend (While and Attwood, 2000). Issues around abortion are evident in educational and professional literature, chiefly concerning the ethics of conscientious objection to involvement (Savulescu, 2006).

One of the reasons for abortion being a visibly ethical issue may lie in the history of abortion in the UK. During some of the participants' professional lives, there had been a strong legal and professional prohibition on providing or facilitating treatment with the intention to cause an abortion. Armstrong, a GP and medical sociologist mentions this as one of the historical prohibitions enforced by the GMC in his sociology textbook for medical students (a book that I used as a student).

...the GMC ... has tended to concentrate on the five 'A's of alcoholism, advertising, addiction, adultery and abortion (though since the legalization of abortion, the latter less so) (Armstrong, 1994).

Roger Higgs (addressing a conference on primary care ethics) echoes this in recalling the single lecture that he receiving at medical school on medical ethics.

Roger Higgs: ...the geezer said, 'There's the rules of As, no abortion, no advertising,' ...a whole load of things beginning with A...

In 'In That Case' (a book referred to by both Dr M and Dr U), Higgs also ascribes (p.10) the prohibition on abortion to a set of values derived from the Hippocratic Oath and subsequent declarations of the World Medical Association (Campbell and Higgs, 1982b). As such, until the law changed, firstly with the case of R v Bourne and then the Abortion Act of 1967, a prohibition on involvement in abortions would have been something GPs were expected to abide by. Furthermore the very term 'ethics' meant avoiding involvement in certain unethical practices such as abortions.

Prior to 1967 the law and professional guidelines offered a simple solution to most dilemmas concerning abortion – it was not allowed unless to save the life of the mother. This may well have reduced the requests for abortions as well as made it much easier to practice with a conscientious objection to the procedure. This did however mean that doctors who believed that an abortion was necessary either refrained with a guilty conscience, or risked professional and legal ramifications.

Following the 1967 Abortion Act the decision to refer for and carry out terminations of pregnancy was placed at the discretion of doctors, with the caveat that there was some scope for doctors to opt out. This opt-out was provided on the basis of sincere conscientious objection and the absence of risk to the life or severe risk to the health of the woman requesting the procedure.

Abortion as an uncomfortable issue

Despite the legal permissibility of abortion, it can be an emotive topic in a consultation.

Emotional discomfort was the other key way in which it was raised as an issue.

Dr M: Abortion can sometimes raise issues that either way it's not great, that one or other choice is not one that you feel happy about...

The discomfort may arise in practice because, as a result of the discretion afforded to doctors by the Abortion Act, the GP can be placed in a position where they have to make a decision.

Dr R: I suppose a fairly common one is the question about abortion ... in the sense that, you know, people come in and say, 'I'm pregnant, I don't want a baby,' you've got to do something about it, and you have to make a decision

The key decision that the GP needs to make in this circumstance is whether the criteria of the Abortion Act are met and whether in good conscience the GP agrees that the benefits of the procedure essentially outweigh the harms for the woman requesting it or whether it is being requested under any kind of duress. Some GPs may also need to decide whether to opt out on the basis of conscientious objection to abortions per se, and whether to outline the basis of that objection to the patient.

Dr R: It's actually a bit more complicated... Well, because you have to decide how much of that you're going to let, you're going to reveal to the patient, and how much you're going to get involved.

For Dr R the balance of values is made more complicated by the decision of how much to tell the patient of the values underlying the GPs recommendations or reluctance to assist by way

of conscientious involvement or conscientious objection.

Discussions around areas such as abortion, where disagreements are shaped by epistemological differences of opinion as well as moral ones serve as stark examples of the potential push and pull of values in the consultation. On the basis that such decisions are not generally taken lightly, it is no surprise that how to respond to requests for termination of pregnancy was described by Dr B (a GP-Trainer) as a live issue for trainees currently.

Dr B: I mean obviously trainees are going to come in with a very sort of obvious commonly recurring problems, like termination [of pregnancy] requests.

Termination of pregnancy, or abortion, has in the second half of the 20th century become an issue for the ethics of practice. The discretion given to GPs and other doctors has been identified in texts and education. This discretion given to GPs to be involved or opt out generates ethical discomfort in some circumstances, and that discomfort identifies it as an ethical issue in practice. The emotional and cultural aspects of ending pregnancy as a medical treatment also generate ethical discomfort. A potential source of that emotional discomfort may stem from the differing values and belief held by the GP and the patient. Dr G illustrates this in the quotation below.

Dr G: I mean, I think in general, doctors function better and patients get a better service from their doctors, if that doctor has as few boundaries between his personal self and his professional self as possible ...the non-medically trained part of oneself can contribute to clinical practice in terms of insight and compassion and riches of world experience and so forth.

It is perhaps unsurprising that some GPs might choose to avoid involvement in abortion irrespective of whether they consider it to be right or wrong.

Abortion as an issue avoided

Abortion can be seen as issue that is sometimes invisible, and subject to both ethical avoidance and ethical deferral. Dr E reflected that abortion would have been much more prominent as an ethical issue in the past.

Dr E: Well I think ten years ago, the old chestnut issues of the morality of abortion ... would have been much nearer the top of the agenda, I think.

A possible reason for abortion representing less of an issue is that in recent decades, patients have usually been able to self-refer to abortion services without ever seeing a GP. Thus many women who seek a termination of pregnancy might never raise the issue with a GP. In areas that are well served by family planning clinics, this is perhaps an issue that might avoid the GP consultation entirely and become invisible as far as the ethics of practice are concerned. For Dr R, abortion was not an obvious ethical issue for practice.

Dr R: ...that's perhaps the most, the commonest one that's not [an] obvious ethical issue...

Importantly it may mean that education about abortion and its attendant ethical issues needs to be provided in order to prepare the new GP for practice in areas that are less well served, or to counsel patients who are unable or unwilling to directly access an abortion service.

Even when a woman does attend her GP to discuss having an abortion, it is not something that most GPs have to refer or be directly involved with unless they are comfortable to do so as Dr R illustrated:

Dr R: I mean the structure is such that you don't actually have to make, decide whether or not they're going to have an abortion, because if you're not happy about it, there are easy ways round it, and, in fact, all you need to do now where I'm in, is give them a piece of paper with a phone number on basically, a little referral slip and they do the rest.

GPs with an ethical aversion to involvement in abortion may choose to use such redirection to avoid an ethically challenging encounter. Passing the patient a referral slip, however, is also a way of avoiding an uncomfortable and time consuming discussion regardless of whether a GP strongly objects to abortion. A key problem with this approach is that the GP may be in a better position to counsel the patient, may have access to their full healthcare record and have established a relationship of trust. The patient may be unwilling or unable to access family planning services directly, and the GP may be able to deal with related issues, such as whether the patient is at risk of sexually transmitted illness or in an abusive relationship. Dr U, for example mentioned that it might represent an issue of practical ethics where a teenager might present with a request for an abortion. In that case the issues might be more concerning issues such as unlawful sexual activity, and whether the teenager is competent to make the decision and have their confidentiality respected. Professor Y stated the necessity of discussing the request to make sure that it was the most appropriate decision.

Prof Y: Well I mean in terms of abortion, I clearly discuss it with the person...

Dr R also expressed the opinion that if a GP holds a fixed ethical view regarding abortion, then dealing with requests is comparatively easier.

Dr R: I think it's fairly easy, perhaps comparatively easy for those people who consider that abortion is wrong in all circumstances. And it's probably fairly... It's pretty easy for those people who consider that a woman has a right to choose in all circumstances.

For many who have ethical difficulty with abortion, this is because beliefs about the sanctity of life and personhood render the procedure as morally equivalent to murder. Whilst I cannot infer that abortion is a live issue only for doctors with strong religious convictions, the most in-depth spontaneous discussion of issues around abortion came from Dr R and Dr E, two avowedly Christian GPs. Conversely, If a person does not regard the foetus as a person, or believes that only the pregnant woman has the right to decide whether to continue with her pregnancy, then the question of what to do will be more easily engaged with. Professor Y was generally in favour of requests for abortion, so the issue became less problematic, illustrating Dr R's point.

Prof Y: ... on the whole I [am] always for abortion, unless it really is an outrageous request, but I always discuss it. So that would not be a problem for me.

The limit to Prof Y's favourable view is the outrageous request. Even where there is consensus about the permissibility of abortion based on women's rights, there may be moral outrage for reason other than the rightness or wrongness of abortion itself. For example selective abortions for cultural reasons such as the preference for male heirs may provoke ethical disapproval from people who would otherwise regard themselves as pro-choice.

A conscientious objection also does not necessarily render the issue easy to avoid. For example some Roman Catholic writers state that deferring to colleagues or to counselling services (who will facilitate abortions) makes a GP morally complicit. For example, two separate articles in

the Catholic Medical Quarterly suggest that a GP with conscientious objection to abortion ought to only refer to services and charities that will encourage and support a woman to go through with her pregnancy, and only to suggest colleagues who are opposed to abortion. Furthermore they suggest that the discussion is an opportunity to find those requests that do not comply with the abortion act, and to give advice about the risks of the procedure in the hope that they will dissuade the patient from seeking an abortion (Watt, 2008, Delaney, 2006). From the position of Watt and others, providing information or referring to a colleague (active avoidance of the issue) will often be morally wrong. Awareness of such advice makes conscientious objection much harder for GPs who hold a sincere belief in the sanctity of human life from the point of conception. Whilst UK law does not consider an embryo at any stage to be a person, someone who believes the embryo to be a person from the point of conception will consider abortion to be the same as murder.

Maintaining a conscientious objection was also regarded as uncomfortable. Dr E illustrates the idea that just because a GP views abortion as morally wrong, it does not mean that he does not recognise the adverse situation that may lead to a request, or that may arise from an unwanted pregnancy.

Dr E: ... I still, and never have done during my entire clinical career, would encourage someone with an unplanned pregnancy to have an abortion. I think that my understanding of their plight and why they want to [have an abortion], has increased enormously over the years.

Dr E also discussed the personal ramifications of conscientious objection. Unlike breaches of confidentiality, which are generally impermissible, referral for an abortion is in effect generally seen as legally permissible, and therefore a refusal to participate or to refer is seen as refusal to provide a service to which the patient is entitled (Savulescu, 2006). Savulescu argues that

doctors' consciences have little place in the delivery of modern medical care. He proposes that people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, should not be doctors. He argues that a service which depends on the values of the treating doctor, results in patients shopping around doctors to receive services to which they are entitled. This introduces inefficiency and wastes resources. The less-informed patients may fail to receive a service to which they are entitled -this inequity is unjustifiable (Savulescu, 2006). Savulescu's argument has rapidly found its way into preparation materials for GP-trainees contemplating Case-Based Discussion Exercises (Naidoo 2007) as a view which GP-trainees are encouraged to heed.

Dr E: I would say it's reprehensible for somebody like Julian Savulescu to take the line that they did in the BMJ famously, about six year ago, to say that, you know, doctors with conscience should not be allowed to practice. It seems to me his argument that you do what the state says or otherwise you're not an ethical doctor, is an extremely flawed one. So you've got to face that brutalising pressure. You've got to face the pressure of having to deal with the very real emotional strains and conflicts that are going to arise in consultation with patients that, you know, you wouldn't otherwise have if you towed the party line.

Whilst participants discussed the potential avoidance of involvement none claimed to have actively persuaded any patient to seek an abortion, or confessed to a tick-box approach to requests in their own practice.

Engaging with the ethics of abortion

The engagement with ethics in practice begins with beliefs and values of the GP and the patient and the discussion will often concern potential points of agreement. Realistically GP and patient are unlikely to change each other's view on the moral status of the embryo. Dr G went so far as to suggest an ethical consensus might not even be possible.

Dr G: ...ethical thinking won't resolve 'is abortion right or wrong?' because clearly if there was an answer, we'd have discovered what it is by now. The fact that there is on-going difference of opinion must suggest that ethics can't resolve it.

Some GPs may not regard the foetus as having full human rights and therefore may view a termination of pregnancy as an extension of contraception or as a gynaecological treatment. The woman's right to choose whether to continue to be pregnant until delivery may be viewed as a value that trumps any notional rights of the foetus. Other GPs may consider that the foetus has full human status from the moment of conception (a view often associated with sincerely held religious beliefs) or that the foetus increasingly acquires moral status from conception to birth. Gillon suggests that these views are not ethical at all but epistemological. According to Gillon, two people may agree that killing people is wrong (the ethical question) but disagree over what counts as a person (the epistemological question)(Gillon, 2001). This makes any kind of ethical discussion very difficult.

Despite an epistemological belief that the foetus does have moral status, some GPs may be prepared to countenance an abortion as be the least-worst course of action.

Dr R: ...But I mean it's this thing about, which I have a continuing discomfort, because I don't have a black and white view ... If you have a Hursthouseian view, which is what I have, that, you know, there are times when, with regret, one will decide that abortion is the least bad course.

Others who did not ascribe personhood to the foetus early in pregnancy might also consider that there are times when abortion is right and others when it is wrong, such as the outrageous request to which Prof Y referred. The discussions I had with participants around the ethics of abortion did not generally revolve around the moral status of the embryo in the eyes of the doctor, but the impact of abortion on the life-story of the mother. Dr M described the nature of a 'right' decision in terms of the patient narrative.

Dr M: ...it's always the one that's most appropriate at that time for that person...

Dr E gave the most thorough description of the immediate and longer term benefits and harms of having an abortion with reference to a specific case. Whilst I cannot comment on the validity of the scientific studies that Dr E quotes (itself a source of fierce debate), there is an unavoidable element of what facts a GP chooses to believe in weighing the risks and benefits in order to counsel a patient.

Dr E: And, you know, the measurement of happiness, I think is something that also needs to at least be debated rather than, rather than assumed. And sometimes of course, what makes a patient immediately happy in the long term may not do so. And in general practice, one sees patients throughout the course of a long period of time. And certainly I've taken a longstanding interest, right from the time of being a medical student, over the whole issue of abortion, and the early studies that were done justifying the mantra that abortion does not harm women, I think were – now generally acknowledged to be very short-sighted that, of course, in the immediate aftermath, if you're faced with the awful dilemma of, you know, having conceived and not feeling that you can look after that child, you're going to feel, in 99% of cases, I would have thought,

immediate relief once the problem has been dispensed with. Most of those early studies only looked at a six month time interval. But now we have more studies looking at longer term sequelae, the psychological consequences I think are becoming more evident. And again one's clinical experience I think informs that. And when, like me, you've had not one, but several women who when they have lost a child in a road traffic accident or a cot death, a subsequent child – I had one patient who rang me up saying, 'What should I do, this is a judgement on me for having a termination.' Now I didn't even know that this woman had had a termination. And that was the first thing she uttered when she picked up the phone. So, you know, one's experience obviously does colour your reading of – and in fact I looked in that patient's notes and saw that the gynaecologist who had referred her at least 15 years before, at the age of 19, was quite convinced that this would do her no harm, and she was a thoroughly modern woman, in quotation marks, for whom this would have no effect at all. Clearly, with hindsight, he was wrong. And I'm sure that this happens with my decisions too. But utilitarian arguments are very short-sighted sometimes.

Dr E conceded that his decisions to intervene in someone's life could also have adverse effects that became apparent at a later point in their life-story. He ostensibly argued that it was important not just to consider immediate but also future happiness in such interventions.

Dr G reflects on whether a GP has a right or duty to determine the outcome of the consultation.

Dr G: ...the ethical issue for abortion for a doctor is not, is not just 'is abortion right or wrong?' but the ethical decision is given that I hold a view either way, have I the right to insist upon it? Whatever my view, have I the right to insist upon it? [...]

Roger Neighbour comments on the morality of influencing patients' decisions in 'The Inner Consultation,' a manual of consultation skills that is widely taught and often referenced (Neighbour, 2007). He voiced the concern below himself at a training course that I attended and conveniently articulates it in his key text as well.

What do you do if you have sound reasons for thinking one option is far better than the others, but the patient chooses the 'wrong' one? I never promised you an end to moral dilemmas. You could accept the patient's choice for the moment, and let time be the teacher; or you could use some of the more covert influencing techniques we shall be discussing shortly. Or you could ask your medical protection society. Or your priest. (Neighbour, 2007)

Neighbour answers his own question. If a GP can influence a patient in that same patient's best interests, then there are times when it is right to do so.

The doctor is credited with expertise, charisma and respect amounting to what Michael Balint called 'his apostolic function'. This lends 'doctor's orders' and authority which, while we may secretly consider it underserved, we should be foolish not to use in the patient's interests. (Neighbour, 2007)

For Neighbour, medical 'authority' is one of many skills or attributes which can be used to the patient's good. His reference to the medical protection society and the priest illustrates the idea that whether, and the degree to which, a doctor 'influences' the patient may rightly or wrongly be affected by both professional and personal ethics.

Substantive issues and ethics Education

Intricate rules and complex reality

Confidentiality arguably sits at a convergence of professional, philosophical and legal principle: a theoretical basis for confidentiality can be justified in terms of deontology (we have a duty to respect autonomy and therefore privacy), consequentialism (if doctors keep confidences, patients trust doctors and disclose more relevant details), virtue ethics (virtuous doctors are discrete and therefore keep their patients private details confidential) as well as other ethical theories.

Confidentiality is an excellent example of ethics as a language of deference – enquiries about confidentiality are about which rules should be followed and when exceptions should occur. Some of the younger participants voice the feeling that they did not have sufficient knowledge, skills or experience to comfortably negotiate confidentiality issues when they arose. The perceived educational need as regards confidentiality manifested in two different ways: Firstly a desire to know what procedure to follow in order to be practising well, and secondly to know when it was appropriate to deviate from the duty to maintain confidentiality. Insofar that rules and guidelines aim to generate morally right or even praiseworthy practice, following them properly was understandably perceived to be important.

However, the general practice literature openly acknowledges the anxiety that can arise where idealistic rules meet complex reality. Members of the RCGP ethics committee recently published a discussion piece in the RCGP newspaper about the challenges of maintaining confidentiality and handling patient data provocatively entitled, 'Is confidentiality a

con?’(Marshall and Pattison, 2010). Marshall and Pattison asked whether current professional ideas relating to confidentiality are conceptually ‘leaky’ and even paternalistic.

The article generated a direct response in the British Journal of General Practice (BJGP) by a very eminent retired general practitioner, Sir Denis Pereira Gray. He re-asserted the ethical promise of confidentiality that instils confidence in general practice:

This doctor-centred article, published in the medical press from two prestigious authors may mislead and worry patients, especially those who read it via one of the approximately 2000 patient groups now associated with British general practices ... Patients often come to GPs in distress, and unburdening themselves can be, and often is, therapeutic. This response seeks to support such patients and to assure them that their legal, ethical, and ministerial safeguards remain in place (Pereira-Gray, 2010).

Perreira-Gray appears to argue that legislation and professional guidance is sufficient to produce ethical behaviour in GPs. He argues that the ethics on display is a good representation of how GPs ought to and generally do behave. An extension of the argument might be that that if GPs have problems maintaining confidentiality, then they must be poorly-educated or unethical.

By contrast, the participant data from this study suggest that ethics education (with particular reference to confidentiality) could be improved, and that issues arising in practice may necessitate disclosure of confidential information rather more than idealistic statements might suggest. I have suggested that there are three key ways in which confidentiality appears problematic.

1. The first problem is that GPs, especially the younger participants perceived confidentiality as the key issue repeatedly arising in practice, but were unsure about how to respond to it. The solution may be part of the problem as trainers describe a

clamour by trainees for concrete facts about the current law and what to do in specific instances, in preference to the skills with which to arrive at a judgement on the correct course of action. This problem may manifest in the discomfort that arises when confidentiality should be breached (sometimes quite urgently) but the GP is not confident that the profession will (with hindsight) support the decision.

2. The second problem is that confidentiality issues often involve conflicting duties, complex demands and uncertainty of both factual premises and predicted outcome. This second problem is more about the difficulties generated by the system in which GPs practice, and, wrongly, a possible perception by some GPs that they should maintain confidentiality at all costs rather than respect confidentiality wherever possible. An absolutist approach to confidentiality potentially spares the GP the moral work (and discomfort) of having to balance rights, benefits and harms. A decision that involves moral work, however may be the best one, and avoidance of such decisions may not be possible.
3. A third problem may be evident in the way that assumptions can be made (usually but not exclusively) by trainees and less experienced GPs that certain people may receive confidential information (and others not). There may be good reasons why information is shared with other healthcare professionals and patients' relatives. The good reasons should be a part of the conscious decision-making rather than just assumed, however, given the store that the profession set by this principle.

The healer's duties, beliefs, and power

Abortion as an ethical issue in practice has the potential to be missed or avoided. There is an argument that issues connected with abortion need to form part of the ethics education of

GPs. This is because, when a GP is presented with a request for an abortion, there is a legal requirement for him/her to make a judgement as to whether the procedure is necessary. This judgement can be avoided, by passing the request to a colleague or to a self-referral service. However neither may be available, and complete avoidance may sometimes be neglectful of other duties. Deferral may still place some doctors with sincere conscientious objections in difficulty as they may see this as a form of facilitation – this is something that requires further discussion from the point of ethics education.

It is helpful to distinguish values from beliefs. Debates about the moral status of the embryo have formed much of the previous moral discourse, but these are only starting points for a conversation in the practice setting. GPs need to be aware of their own religious and scientific beliefs and to reflect on how these influence the advice that they give to patients. Beliefs in this instance may include beliefs about the moral status of the embryo or about the potential harm to the mother of continuing with or terminating a pregnancy. Participants' discussions centred very much on belief about the mother. The idea that an abortion is a tragic necessity is one which some GPs with a belief in the moral worth of the embryo may use to justify facilitating a termination of pregnancy. Similarly a GP with no such beliefs may still consider an abortion request to be outrageous.

All doctors in the UK are under a professional obligation not to allow their own values and beliefs to prejudice their work. However, given that GPs are expected to influence patient's decisions, can they operate in a state of moral neutrality? The ethically sensitive GP must decide how far they will allow their values to influence the patient, and how far they will allow their patients' values and choices to influence their actions. There is an argument that where a GP believes that s/he will do some good for a patient s/he should attempt to influence and persuade them. GP must decide to what degree they should display their espoused values and

beliefs, and acknowledge any particular source of moral values that the patient would consider to represent a conflict of interests. A declaration of beliefs may undermine that ability to persuade. The ability and duty of the GP to influence patients is remarked upon by GP educators (Neighbour, 2007) and in the ethics more generally (Brody, 1992) and perhaps this is one specific circumstance that might be focus for further work.

Chapter 9: Substantive ethical issues encountered in General Practice

(Part 2)

Introduction

This chapter continues the exploration and analysis of substantive issues in general practice ethics. Although there is no clear-cut separation of the ‘personal’ and ‘social’ dimensions of ethics (as well illustrated in the discussion of confidentiality for example) it is important to recognise that the ethical work of GPs takes place under financial (and other social) constraints which, by necessity, help shape their deliberations. GPs are certainly not free-floating agents who can simply and purely choose to do what they see as the best for the person in front of them. The issues discussed in this chapter – financial incentives and rationing – are chosen both because they featured in the data and because they help to illuminate this additional ‘real world’ dimension. As in the previous chapter most of the discussion will be given over to understanding the nature and complexity of the ethical substance but I will conclude with some brief reflections of the implications of the exploration and analysis of these issues for ethics education.

Financial incentives in primary healthcare

Recognising financial incentives as an ethical issue

Financial incentives are not an issue that dominates medical ethics education in the same way that euthanasia or confidentiality has generated a vast academic and educational literature. However the issues generated by financial incentives in medicine are to an extent represented in both mainstream medical and general practice literature.

The QOF is not the only way in which the decisions to collect data, provide certain interventions and to restrict others is incentivised. However it serves as the main illustration of participants' awareness that payment linked to performance could be ethically problematic. It is also a pervasive element in English general practice.

The QOF contains four main components (domains). The four domains are: Clinical Domain, Organisational Domain, Patient Experience Domain and Additional Services Domain. Each domain consists of a set of achievement measures, known as indicators, against which practices score points according to their level of achievement. The 2010/11 QOF measured achievement against 134 indicators; practices scored points on the basis of achievement against each indicator, up to a maximum of 1,000 points.

- **clinical care:** the domain consists of 86 indicators across 20 clinical areas (e.g. coronary heart disease, heart failure, hypertension) worth up to a maximum of 697 points.
- **organisational:** the domain consists of 36 indicators (worth up to 167.5 points) across five organisational areas – records and information; information for patients; education and training; practice management and medicines management.

- **patient experience:** the domain consists of three indicators (worth up to 91.5 points) that relate to length of consultations and to patient experience of access to GPs.
- **additional services:** the domain consists of nine indicators across four service areas – cervical screening, child health surveillance, maternity service and contraceptive services.

The QOF gives an indication of the overall achievement of a surgery through this points system. Practices aim to deliver specified services across a range of areas for which they score points. Put simply, the higher the score, the higher the financial reward for the practice (Papanikitas, 2013). The final payment is adjusted to take account of surgery workload and the prevalence of chronic conditions in the practice's local area.

Though it is a pervasive and, some might argue, unavoidable aspect of practice, the QOF should in theory be invisible as an ethical issue. Misselbrook, for example, illustrates this presupposition that the values of the profession, patients and the state should be in alignment (Misselbrook, 2010).

Misselbrook: Surely then QOF must represent a win-win situation? *GPs* are happy that hard work is rewarded. The [*Department of Health*] is happy that perverse disincentives are reduced and the [statistical] 'tail' of poor general practice has finally been addressed. And *patients* should be happy that they can be confident of receiving the best quality of care. [Italics added to quotation]

If all stakeholders were happy as in Misselbrook's clearly rhetorical suggestion there would be no ethical controversy. By its very nature QOF itemises clinical activity and links the items to reimbursement, and so it is no surprise that it places the discussion of such items high on GPs' agendas. However, references to the ethical aspects of financial incentives do appear in medical journals. Those which I found concentrated on the QOF and tended to be critical of

incentives as a means to better healthcare (Kramer, 2012, Misselbrook, 2010). Discussion of the QOF in terms of ethics also finds its way into the correspondence pages of the trade press. QOF has also begun to be discussed in medical undergraduate text books though it might be discussed under a heading of promoting population health (Booton et al., 2013b) rather than ethics. On this basis, there is the potential for financial incentives to be pre-identified issue.

Financial incentives and ethical discomfort

As well as being recognised in the literature as ethically problematic, financial incentives (especially QOF) were recognised by participants as a source of ethical discomfort.

Dr G: I do genuinely believe that the effect of QOF has been to put a lot of doctors under quite serious ethical dilemmas, as to their priorities with patients in the consultation. I think that's a very real issue.

The tasks generated by QOF competed with other clinical activities aimed at service improvement and patient welfare. Occasionally adherence to targets was inappropriate and this risked harm to individual patients. Another area of discomfort was where a GP perceived that an incentivised task conflicted with advice from the latest in evidence-based medicine. Regardless of whether QOF targets were based on good clinical evidence, they were perceived to conflict with a professional ethic of holistic, person-centred care. All of the participants who discussed financial incentives had been in practice prior to the introduction of the QOF in 2004. None of the younger participants raised this as an issue, begging the question of whether this had become an issue that was invisible as a topic for ethical discussion and consequent ethics education. None of the participants discussed a need to explain financial incentives to patients. By contrast participants did raise the issue of discussing confidentiality, healthcare rationing and abortion with patients.

Incentives in conflict with other patient needs

A significant proportion of income for a practice comes from the achievement of incentivised performance targets. Consequently, a significant amount of time and effort is put by members of the practice into planning how they can best be achieved.

Dr B illustrated how the achievement of QOF targets can dominate discussion at the practice management level. This was at a cost to the discussion of individual cases.

Dr B: ...we were reflecting as a practice the other day, that ten years ago, when we met over coffee in a sort of haphazard way, every day, and in our weekly team meeting, we spent most of our time, well most, certainly a very large chunk of our time, discussing individual cases.

Whereas now we spend most of the time on practice administration and QOF.

It is intuitive to suppose that GPs with managerial responsibilities for and a financial stake in the services that they provide (partners) might have greater awareness of financial incentives in practice.

Prof Y: I don't do them ... The QOF things. But I'm not a partner... I mean I have some responsibility to the practice, because they pay me, but it's not the driving force. And I don't think it is, to be fair, the driving force by the partners, but because they know more about it, how far we are from our targets and all the rest of it, they are bound to be more aware of it.

None of my participants suggested that GP-partners were disproportionately influenced by financial incentives. Prof Y suggests that salaried GPs might also feel a duty to their employers, whether this was out of a desire keep one's job or to make sure that the service received sufficient funds to run. Dr G suggested that this was a powerful issue for young GPs as well, primarily because of potential conflict between GPs' and patients' agendas.

Dr G: ...one [issue] that's clearly very, very powerful at the moment, which I think lots, particularly young doctors, are very confused by, is, is the tension that exists between the doctor's agenda and partly QOF driven for instance, and the patient's.

In the consultation itself, all English GPs are reminded to perform QOF-related tasks by messages that appear on the computer when they open any given patient's healthcare record.

Prof Y: I think in principle it [raises ethical issues], because when these little things pop up on my screen, 'Ask them about this, that and the other,' and they've come with other, particularly their intimate problems

Dr R: You're making a moral decision every time you decide whether you're going to do the QOF things or forget them...

There are two potential GP's agendas implicit in meeting QOF targets: In so far that the targets are supposed to be evidence-based activities which benefit the public good, and even benefit the individual patient, the doctor's agenda may be one of beneficent paternalism. However in so far that the QOF targets are associated with a significant proportion of practice income, the doctor's agenda may be ensuring income for the practice. Whatever the rationale behind the doctor's agenda, the patient's agenda may differ and conflict, for example because the patient has different values and beliefs.

Incentivising bad medicine

The QOF is ostensibly evidence-based in that the targets are in theory based on gathering data that will be meaningful to plan services and on providing chronic disease management that will benefit and not harm patients. Both data gathering and chronic disease treatment aspects have been critically questioned.

Whilst I did not have participant data questioning the evidence base for data gathering linked to the QOF, this found its way into the correspondence pages of trade publications such as the following 'Prize letter' from BMA News.

Most doctors in the NHS work to targets, but are they all ethical? And if doctors receive payments as a result, what then? An editorial about health checks in the BMJ on November 20 (2012: 345; e7775) says they are not effective, yet GPs have been asked to meet them and get Quality and Outcomes Framework points. Depressed patients have to complete two hospital and anxiety and depression questionnaires for new diagnoses in primary care; the National Institute for Health and Clinical Excellence advises that this is not an effective tool, so why are GPs and patients doing this? ... We have to practice evidence-based medicine, but who makes health secretary Jeremy Hunt pursue ethically and evidence-based policies? (Neaves, 2012)

The QOF incentivises prescription of numerous medications for chronic illness which are targeted at measurable endpoints such as the lowering of blood pressure results or blood sugar measurements. Misselbrook describes the resultant increased prescribing as a 'two-edged sword.' He cites evidence that iatrogenic illness relating to poly-pharmacy accounts for many admissions of older people to hospital (Misselbrook, 2010). Professor P described a circumstance where following guidance incentivised by the QOF will potentially harm a patient.

Prof P: [I have come across queries] about the evidence underpinning blood glucose control in diabetics, particularly elderly diabetics and how people feel that the –actually interestingly, the words [GPs] use are, 'We're being made to do certain things that we think are dangerous for patients.' To which my response would probably be, 'Actually you're not being made, you're being incentivised.' So we see the difference between being incentivised and being made to do something. But, you know, that is an interesting issue, there's probably sufficient evidence now

to, to suggest that we shouldn't be controlling blood glucose as tightly in the elderly as QOF would encourage us to do so. And that might be possibly dangerous. So what are the consequences of GPs recognising that factor and what should they do about it?

In the above quotation Professor P makes an important distinction regarding the influence of financial incentives. The measurable physiological or laboratory result is what is incentivised rather than a positive outcome that is more immediately meaningful to individual patients.

Incentives are not unbreakable rules, and GPs are at liberty to potentially earn less, if gathering data from and treating patients to achieve statistical targets are not relevant. Furthermore, patients who refuse to cooperate with the QOF, and patients for whom the targets are inappropriate can be exempted without financial loss. Although, exempting large numbers of patients without good reason and without a reasonable attempt to meet the QOF targets is considered to be a kind of fraud. Accordingly, GP practices with high levels of exemptions are more likely to be investigated. Official scrutiny carries an attendant threat of discovering some form of inadequacy and an additional administrative burden on the practice being investigated.

Conflict between financial incentives and the general practice ethic

In previous chapters I have already alluded to the idea that as a profession in the UK, general practice espouses an ethic of holistic patient-centred care. This ethic is embedded in both GP-training and in the contribution of general practice to undergraduate medicine. Working with a system of financial incentives that is predominantly disease-orientated and predominantly

focuses on quantitative measures irrespective of patient well-being can be a source of ethical discomfort. Kramer described this as a worry in the British Journal of General Practice.

I had worried that, by being paid to implement evidence-based guidelines, my work would become a restricted, target-driven exercise that shifted the balance of my consultations to a doctor and disease-centred agenda (Kramer, 2012).

Professor P and Dr G, two very senior GPs within the profession suggest that the tension between the ethic of patient-centred care and disease-focussed incentives can occur at a corporate level in general practice.

Prof P: ...sometimes it's a high level. If you're incentivising certain biomedical practices, which are easily measurable, what happens to the less measurable aspect of general practice, and there's concern amongst, there's concern amongst certain member[s of the RCGP] that we stop thinking, that we're practicing good evidence based medicine, but we're not behaving like generalists any more. So sometimes it's a kind of a high level concern about the direction of travel of medicine and biomedicine and general practice in particular.

Dr G: I think there's a greater tension between corporate professional ethics and political expectation at the moment.

Misselbrook (Misselbrook, 2010) argues that the QOF hijacks the patient's agenda and replaces it with a biomedical target that is driven by the agenda of doctors and politicians to agree on measurable targets linked to payment. Dr G gave a dramatic example of how the ethic of patient-centredness might be challenged by the QOF.

Dr G: Now the big principles don't help with that at all. I mean you can make a case for – let, let's say, let's say that you're 'Minute nine' in the [ten minute] consultation and the patient looks

about to burst into tears, but you've got a reminder that says you haven't checked his blood pressure, how are you going to use that last minute? That's an ethical issue. You can't resolve it by reference to any of the broad principles, because you can make a case for doing either in terms of its justice to the community at large, that the hypertension is properly documented, it's right for the individual patient, for their agenda to, you know, to predominate ... So in the example that I've just given you, if in the last minute, the pressure of being under time constraints, if you could follow the QOF points or follow the patient's tears - what you actually decide is an expression of your values. And if you actually got the QOF points, I won't believe you when you say you're patient centred, because your actions, not you personally, your actions confound that.

For Dr G this was a circumstance where an espoused value of patient-centredness meant letting the patient's needs predominate. Ethical arguments could be made using the four principles that the QOF target should be achieved, but this does not stop adherence to the QOF from conflicting with the espoused value. The example that Dr G uses seems extreme, and it appears intuitive to attend to the patient's distress rather than to measure their blood pressure.

Avoidance of financial incentives

It is possible to avoid thinking about the QOF, especially for GPs who do not have a direct duty to balance practice finances. Professor Y, for example was able to abdicate responsibility for gathering sufficient QOF-data to others, and did not have any great knowledge about which items resulted in practice income and items did not.

Prof Y: ... I don't know what the QOF payments are in the practice, and I don't concern myself with the administration about it ... So I feel much more for the person in front of me, i.e. the patient.

She compared herself to the practice partners, who might be more aware if the practice was not meeting its targets. Exemption of patients for whom QOF is inappropriate is not a form of avoidance and does not in theory cost the practice any money. Avoidance of the issue by simply not attempting to engage with the QOF can have significant financial ramifications for the practice. It also ignores the public health benefits of gathering data and treating chronic disease proactively.

Professor Y, however, qualified her position on the QOF. She was prepared to gather data ostensibly for the QOF so long this did not interfere with the consultation.

Prof Y: Now if it seems appropriate within the consultation to ask about smoking, alcohol and all the rest of it, then I will do that for QOF, okay. But my primary responsibility is the person coming to see me, and that's how I see it.

Professor Y's qualification was that that her primary duty was to the patient. Patient-centeredness was the key value that prevented patients being disadvantaged or even harmed by financial incentives. However, awareness of the incentives and the rationale for them means that GPs can be opportunistic about gathering data and can be reminded of best practice in managing the chronic diseases featured in the QOF.

Rationing

Rationing and resource allocation have been an issue in the GP consciousness for some time. Recent historical developments have made the concept of rationing an issue for practice both at strategic and the consultation level. Participants used the terms, rationing, resource allocation and commissioning but all these terms are employed in a context of finite resources. Consequently I have discussed them under a main heading of rationing.

Rationing identified

An approach to rationing has been certainly taught on undergraduate medical ethics courses for decades under the subheading of 'justice'. Justice, the concept of treating equals equally and unequals unequally according to the morally relevant inequality is one of the 'four principles' of bioethics that is widely promulgated by Gillon and others in the UK (Gillon, 2003, Booton et al., 2013a). Dr R explicitly connected justice to resource allocation.

AP: What would you say are the top four issues of an ethical nature that might impinge on...

Dr R: Justice and resource allocation, which is everything from referral decisions to how long you spend with the patient, whether you prescribe a cheaper or more expensive drug, that must, that's got to be the biggest one, because that happens most, that involves most consultations.

And do you feel that you have to make decisions of that nature as a GP?

Dr R: Of course, every day

Dr O referred to equity, but used the term synonymously with justice -he listed equity in the place of justice when reciting the four principles he had learned in medical school.

Dr O: I find that equity is absolutely fundamental through all my work as a GP [...] I find, and I find it of paramount importance Again I don't know if I'm blurring the boundaries, but for me being a general practitioner is about, you know, fundamentally about managing resources, being

a gatekeeper of resources and directing resources parsimoniously to those who need it. So equity is of fundamental importance, I consider, in my work.

Dr O identified a role of the GP as being a gate-keeper, someone who will refer some and deter others from accessing specialist healthcare depending on each person's clinical need. In this sense a GP acts as an agent for National Health Service, which offers healthcare that is funded by taxation, equal and free at the point of need. Dr O's commitment to fairness was not unique.

At the time I conducted my fieldwork, there was an imminent change in the legislation of healthcare provision, with more explicit roles for GPs in the allocation of health resources. This change came in the wake of a major economic recession, which was accompanied by much public rhetoric about cost-cutting in the public sector. As Dr M (below) suggested when I asked her about big ethical issues, rationing is a visible contemporary issue.

Dr M: ...actually much more now rationing, resource allocation...

Participants reflected on idea of finite resources that are inadequate to cater completely for clinical need. Prof P felt that this was an area of ethical complexity that would become more prominent in ensuing years.

Prof P: I mean the credit crunch of course didn't really have any impact on the health service. It's going to have an impact over the next three or four years. I think most people don't realise quite how significant that impact will be. And I guess that's what I was alluding to around commissioning, how our decisions are going to have to be made ... So I think it's going to be very tough and a lot of ethical issues will come to the fore as a consequence.

Dr U gave an example of an imminent crisis of healthcare resources in primary care.

Dr U: ...eighty billion sounds a lot of money until you realise that, in reality, taking over now – homecare which has previously been means tested and funded and no longer, allegedly, will be the case. The government are attempting to drop about £180 billion worth of problems on primary care.

Dr U's simple point was that there is a budget of £80 billion for problems worth £180 billion. Therefore some people's needs will not be catered for. His figure of £80 billion is the stated budget for primary care trusts in 2009/10 (King's Fund, 2011).

Rationing as a source of ethical discomfort

Particular concepts allied to rationing emerged as sources of ethical discomfort. The first was awareness that resources given to one patient or group of patients might result in resources being denied elsewhere. If resources are perceived to be limited, then any perception that their allocation occurred in a manner that was unjust resulted in disquiet. This was especially if that injustice originated in a preference or belief held by the person doing the allocating. Whilst participants were quiet on the issue of discussing financial incentives with patients, discussing resource allocation with patients was an unavoidable source of conflict and difficulty.

Awareness of opportunity costs

If resources are limited, then the economic concept of opportunity costs gains relevance. This dictates that resources expended in one area of health care are unavailable for expenditure

elsewhere (Bradley, 1999). Participants were aware of opportunity costs and that giving to one person could deny another. Opportunity costs were described in terms of two resources, finance and time.

Dr R had alluded to whether to prescribe any given patient a more or less expensive medication. The implication was that the more expensive one might be better.

As we have seen elsewhere in this section resource was often seen in terms of finance. Drs U and W illustrate this.

Dr U: Every decision we make has a financial implication.

Dr W: ...around commissioning decisions we already make are, in practice, there's not a surgery I've done where I haven't prescribed something, I haven't sent a patient off for an investigation or referred them on. All of those cost money to the taxpayer... But I do that day to day. So therefore as a GP I'm a commissioner every day ... most GPs are commissioners, we just don't label them as commissioners.

Dr R brought home the point about opportunity costs in terms of time spent with each patient. For Dr R as with all other who discussed resource allocation, this was an ethical issue.

Dr R You're making a moral decision every time you decide whether you're going... to, when the patient raises a cue that you know could reveal a whole lot of stuff which you could take ten minutes, take ten minutes over, whether you actually respond to it or whether you say, 'Well here's the prescription,' and terminate the consultation, because – and, because you're giving, it's time for the next patient.

The involvement of GPs in resource allocation sits at odds with the espoused duty to act as advocate for the patient, whether it is the patient who consults, a patient who is registered with a GP or a population for whom the GP has a responsibility.

Conflicts of interest

A source of discomfort around the ethical allocation of healthcare resources may stem from conflicts of interest, where the person doing the allocating is perceived, rightly or wrongly to be doing this unjustly. Commitment to a specific group of patients, preserving the financial viability of local services, and the less altruistic desire to maximise personal income were also presented as sources of conflict of interest. Some might also argue that beliefs about the effectiveness of particular treatments might constitute a conflict of interests. I have discussed such beliefs under a separate heading below.

Professor Z described his awareness that, by obtaining funding for his practice, he was denying it to others who might potentially benefit. In effect he presented the idea that a pre-existing commitment to a patient or group of patient might represent a conflict of interests.

Prof Z: [A case] that I remember quite vividly was, was a distributive justice issue, about our practice's application to [primary care funding body] to have funding for psychotherapists to come to the practice, and we fought hard for that [...] But all the time I personally was worried, though I didn't - only in a theoretical way, worried, because I didn't do anything about it - that other practices that weren't fighting so hard and didn't play the game of getting funding for their practices, quite so effectively, weren't getting that sort of help for their practices, and therefore, for their patients. And you know, the balance between a concern for our own practice population and between, I don't know, all the patients in the local area, and then of course in a theoretical way, how to balance the needs of all sick people, you know, across the country as a whole, or regions of the country, or indeed internationally. You know, that's the sort of dilemma

that, in the end I think one simply has to choose [...] who you give your benefits to and who you don't give your benefits to. [...] And I suppose, you know, the reason I didn't pull back from applying for our own psychotherapists was that I feel it's actually proper to give priority to the people to whom you are specifically committed, and that, of course, is another tension in the area of distributive justice.

Professor Z's rationale does not need re-explaining. However, his example illustrated the idea that we may tend to look after local interests first and do not necessarily live our lives in a manner that helps those in most need. Indeed Professor Z's patients might have been relieved to know that their GP was looking out for their interests in preference to those of the region, the country or the world! If Professor Z had telephoned around his colleagues regionally to see which GP had the most patients in psychological distress, and then helped that GP to apply for the service, he might have been failing in his duty to 'his' patients.

Another source of anxiety is connected to decisions to prefer certain local services in the allocation of resources because they are better in some way. This can be subject to accusations of unjust preference.

Dr W: There will be services I'd be commissioning to a colleague who I've known as a GP as working with [GPs with a special interest], so the community services. I don't necessarily refer to him because I think he's getting money from it, I refer to him because I think that's what's clinically appropriate.

Dr W's answer to allegations of unjust bias was that the superiority of the chosen service should be explicit.

When conflicts of interest are discussed it is often less altruistic conflicts that are discussed. Dr U felt that selfishness in terms of resource allocation decisions was to be expected as a facet of human nature. Unless run directly by the state (not the norm) GP surgeries are set up as small businesses.

Dr U: GPs are human beings, there are going to be practice issues, there are going to be their families saying, 'Well what's in it for us as a business?' I mean no doctor in my view, who is locked in to a practice, who has had to invest half a million quid in the business, who's looking forward to getting a million and a half or three million quid out when they retire, can be entirely objective on medicine, because they are always going to want and prefer their business, that's human nature. ... But the argument is, if they're all in it together, they can all fight amongst themselves, divide and conquer. That's supposed to be management? Ha, ha.

Dr U was disparaging of the idea that enlightened self-interest would lead those with a financial interest to give the highest quality service for the least cost on the basis of competition. He suggested that the only way to avoid any perception that a commissioner of services is unaffected by financial bias would be to remove any financial stake other than the incentive to do the job well. He gave the example of a locum GP as someone without a financial stake or contractual tie to any one GP practice or group of patients.

Dr U: So you need somebody who's got no financial interest whatsoever to deal with that. You know, above it ... Certainly I would argue that locums, because they are not locked into practices, are probably the people to lead commissioning groups ... because they can look objectively at medicine and dilemmas and they are not running a business ... if you've got a senior locum, with running the commissioning group, and they are being paid, I don't know, 100 quid an hour, whatever it is, simply to work as a salary, and can be sacked if they're no good, then as far as the

others are concerned, they are not favouring one particular business over another business, because they've got no interest in any of the businesses.

The potential difficulty with stripping away all aspects of a GP that might give rise to the smallest suspicion that there is a conflict of interest, is that this also strips away some of the value of decisions made by a medically and locally knowledgeable person who has the local population's interests at heart.

Discussing rationing with patients

Conversations with patients where a desired service is being denied, delayed or restricted are perhaps inevitable – In my own GP-training a conversation about how to tell someone that they should accept the cheapest effective version of a drug rather than the newest and most expensive is was used as an archetypal scenario.

When discussing a decision that is influenced by awareness of the need to preserve resources, there is a discomfort in being perceived as denying something that could be beneficial to a person's health. Similarly there is potential conflict in denying patient requests, as Dr O illustrates.

Dr O: And I fear that many of my patients might object that I consider it too much in relation to their needs for patient autonomy. I don't find the two mutually exclusive.

The suggestion that Dr O makes, that patient autonomy and justice are not mutually exclusive, relies on persuading a patient (without deception) either to accept the phenomenon of rationing or to accept a reasonable alternative to their request. Where patients had unrestricted means to access services, there was less of an onus to prove that the treatment would be beneficial.

Dr E: But now, with 27 years of experience behind me, I've certainly come across anecdotal cases of my patients seeing homoeopathic practitioners and particularly with conditions like eczema and asthma, getting much better... And if they have a condition like eczema which either the treatments may not work very well, or if they do, it's at a cost, and patients are aware of the problems with steroids and so on, I now think to myself, 'Well I may [not] believe in it, but I certainly don't believe that it does any harm, because that's why it doesn't work, it's a neutral treatment, and if the interaction between the homoeopathic practitioner and the client can lead to an improvement in their or their child's eczema, in a way that I cannot, then who am I to, you know, denounce it? And though I would still say there was a principle about paying for it, I am not happy that the PCT pays for it, but now I will happily refer if the patient is paying for it.

Dr E illustrated the double standard with respect to complementary and alternative medicine. Given that there was doubt about the efficacy of a treatment, the treatment should not be funded by the NHS. However, given that a treatment would cause no harm (for example by causing side effects or leading to avoidance of conventional therapy) he was happier to facilitate a private referral for alternatives to mainstream western medicine.

Given that Dr E would have to explain why he could not in good conscience advocate NHS resources for homeopathy, his reasoning might ultimately be less about ethics and more about belief.

Dr E: And again it comes back to this thing about, you know, what are you doing, are you educating the patients about, you know, evidence based medicine?

There is no guarantee that educating someone about what treatment will be efficacious will make them definitely agree with a GP's recommendation.

Dr E: I have seen the hostility that that's induced in patients... And sometimes they don't come back to see me. And I don't think that's usually, you know, an outcome that I want to aim for too often.

Dr E reflected that some of the patients whose preference for complementary medicine he had challenged simply chose not to consult with him again. Iliffe suggests that age, socioeconomic status and ethnicity all conspire with different understandings of science to establish distinct explanatory models, and distinct experiences of illness and medical care (Iliffe, 2001).

The epistemology of resource allocation

My fieldwork for this study revealed two potent sources of controversy around rationing and resource allocation. They were not about ethics but about beliefs relevant to ethics. In the first instance there was the belief that if waste were eliminated from healthcare, rationing would be unnecessary. In the second instance there were beliefs about what constituted effective use of healthcare resources. Beliefs about effective healthcare were closely tied thematically to beliefs about evidence based medicine.

Beliefs about minimization of waste

Government officials may publically deny that rationing is necessary and even use threatening language when the word is invoked. For example Conservative Health Minister Earl Howe, quoted here in a GP newspaper (Moberly, 2012) condemns rationing based on cost.

Howe: We have been clear that it is completely unacceptable to impose blanket bans on treatments, or to restrict access to treatments on the basis of cost alone. We have made it clear that we will take action against any organization found to be arbitrarily restricting treatment without clinical justification...

I watched Earl Howe make an almost identical comment at the 2012 RCGP Annual Conference, to over a thousand members of the RCGP, including trainees and newly qualified practitioners. His comments were met with some disbelief. Implicit in Earl Howe's statement is the idea that it is wrong to restrict access to treatments that work, especially when there are treatments that do not.

According to Brody, ethicists arguing for fair rationing have had to contend with claims that the cost problem would be solved if waste were eliminated (Brody, 2012). They have replied suggesting that eliminating all waste would result in one-time savings; the primary drivers of cost escalation — technological advances and the aging of the population — would proceed unchecked. Brody argues that if waste is defined broadly as spending on interventions that do not benefit patients, this actually amounts to a much larger sum and is a major driver of cost increases

The two principal ethical arguments for waste avoidance are first, that we should not deprive any patient of useful medical services, even if they're expensive, so long as money is being wasted on useless interventions, and second, that useless tests and treatments cause harm. Treatments that won't help patients can cause complications. Diagnostic tests that won't help patients produce false positive results that in turn lead to more tests and complications (Brody, 2012).

Brody's approach is implicit in Dr O's parsimonious approach to resource allocation which I referred to at the beginning of the section on rationing. It may have been a reason why he did not consider that his approach was inconsistent with other ethical values. The belief that

controlling waste in the system will avoid rationing is a convenient one, whether held by politicians or doctors, because it avoids taking full responsibility for restricting beneficial care.

Beliefs about the effectiveness of treatment

Beliefs about the morality of restricting treatment in the presence of waste were further epistemological questions about what constitutes a beneficial treatment and what constitutes a waste. Dr E used the example of complementary medicine as an example of something he felt was a waste of money.

Dr E: So if I can return to my sort of hobby horse about waste of money and so on, I practice in a very fashionable area, where I get lots of requests for... I'm asked to get a referral to the Royal Homoeopathic Hospital, my heart absolutely sinks because I personally think that homoeopathy is bunk and has no proven value at all and a total waste of money.

General practice (and healthcare more generally) in the UK claims to be scientific and evidence-based. This does not allow room for alternatives, especially with respect to the allocation of state funds. Dr W, a GP and healthcare commissioner compared the UK to his experience of healthcare in China.

Dr W: ...I was in China, and in China their medical model is definitely not a biomedical model the way we think of it. And they have a very inclusive approach. ... they have a very justifiable argument to say, well Chinese medicine existed long before Western medicine did. And there's something cultural around how in the West the doctors have approach, which has meant we've excluded many other things. And whereas their approach in China at the moment is, if you go to a Chinese hospital, actually they're dual trained or they're open to complementary – I wouldn't use the word 'complementary' there, open to what I describe as their mainstream medicine ...

And things like acupuncture are about as standard as writing a prescription. And they do, if you speak to anybody about Chinese medicine, actually their formulations are not too different to how we formulate a diagnosis. So it's, it's an interesting one from that perspective. It's made me rethink actually my very rigid hard-nosed Western view.

If the UK medical profession do not believe in the basis of Chinese medicine, and the evidence for its effectiveness is also lacking, it seems unlikely that they will advocate its funding by limited state resources. Both Dr W and Dr E's personal views on alternatives to western medicine had softened with experience. However, both conscientiously would only use public funding for treatments that were endorsed by evidence-based medicine.

Dr W: [It has not] changed what I have to do because I have to justify public finance, when it comes to making decisions here, but there is something around acknowledging that we have a very restrictive practice rather than an inclusive practice. ... as a commissioner, I wouldn't go with the commissioning of a non-numerical, unquantifiable service with very little evidence base, because I just wouldn't be able to stand up and justify that as we cut other services where is there a lot more evidence to it.

Western medicine by definition excludes alternative systems – if science is truth then alternatives are delusions and lies. Edzard Ernst, the UK's first professor of complementary and alternative medicine argues that complementary and alternative practitioners can be unethical in three key ways: their methods cannot be explained by western science, their results cannot be substantiated, and they have no robust professional oversight to regulate their behaviour (Ernst, 1996, Ernst, 2009). Practitioners are accordingly acting outside of an officially recognised role and therefore, by definition unprofessional.

An ethical issue arising out of diversity within society as regards culture and belief is the public support for treatments that are not recognised by western evidence-based medicine. This has in many ways taken the debate over whether to prioritise patient preference or clinical effectiveness to a strategic and even political level. It echoes the conversations between GPs and patients at the consultation level.

Dr W: About five years ago we had a whole debate around homoeopathy when we went through last cuts ... And across [the city] we'd agreed to pull the contracts on [a homeopathic hospital]. And when we did that, you know, there was a, 'why could we do that, because it was a very target of saying well I guess everyone sort of likes it, but we're not quite sure what it's meant to be doing.' So on a numbered scale, you know, they could show a very high satisfaction rate, everyone liked staying there. But actually what benefits it could bring to that individual ... it's actually quite hard from a commissioning perspective to try and justify why you would ever take it up.

Clearly there may be a spectrum of belief regarding the effectiveness of both western medicine and its alternatives. In a context of unrestricted resources the main limiting factor at a consultation and a commission level might be avoiding harm whilst maximising choice. Participants illustrated this by the willingness to privately refer for things that they would not endorse on the NHS. One might expect that the spectrum of belief is wider outside the medical profession, because adoption of certain beliefs and values are necessary if one is to successfully qualify and practice without censure.

Avoidance of responsibility for rationing and resource allocation

Whilst GPs may claim to 'husband' resources to eliminate waste and make those resources as effective as possible, they are keen not to identify themselves as deniers of essential

healthcare. Misselbrook flippantly refers to GPs as the 'good guys' who don't switch off children's ventilators in an editorial welcoming ethics discussion in the BJGP (Misselbrook, 2012). This dissociation from or avoidance of involvement in rationing decisions was evident in discussions with participants.

Professor P suggested that some members of the RCGP were concerned about the idea of a visible role in managing healthcare resources at a regional level.

Prof P: The [RCGP] has been overall supportive of the direction of travel of the White Paper, but there are members who are concerned. [There have been a lot of discussions] from people who feel very strongly that the White Paper is heading in the wrong direction, asking GPs to do things that are unacceptable, particularly around the commissioning role and holding budgets and making rationing decisions.

Dr W, a GP with a senior commissioning role reflected on the idea that GPs felt some distaste for being seen to be in control of healthcare resources.

Dr W: ...suddenly now we're described as commissioners, suddenly we feel this may not be the right thing for us ...I think we're brought up with the idea that we distance ourselves from, we've not handled money, because I think money itself is something that we've been taught is a dirty thing to talk about and is morally wrong. And so we've learnt to dissociate ourselves from it. And nobody ever talks to me or anybody else [to say], "You commissioned a thousand pounds' worth of activity in the local community." And I find that quite hard. As a GP I find it quite hard to take on board.

In their recent qualitative study of resource allocation decisions by 24 inner-city GPs, Berney et al found that none of their participants questioned the moral premise that there should be

equal access to healthcare based on equal need, free at the point of delivery (Berney et al., 2005). However GPs often complained of having to explain or justify decisions made by others but which patients believed had been made by their GP her/himself (Berney et al., 2005). This is evident in Professor P's description of 'blaming someone else' for the unpopular decisions.

Prof P: ...whereas in the, you know, when I was practising as a fund holding GP or even prior to fund holding in the late eighties, early nineties, and hard decisions had to be made around prioritisation, I could always blame somebody else. You know, our health authority is telling me I can't fund X. As an active commissioning GP, I wouldn't be able to do that.

The public identification of GPs as people who make decisions to restrict resources is new and sudden. The dissociation from decisions made at a higher level allowed GPs such as Dr E to take the side of the patient and denounce those decisions that appeared poorly made.

Dr E: I think that issues of being open with the patients about the conflicts between an increasingly centralised controlled practice and why we're doing things as we are, and these dilemmas seem to me to be becoming more and more frequent and an everyday affair. And the example that comes to mind is that our primary care trust has installed Scriptswitch, a generic switching software into our computers. We weren't asked our consent about that. It was just done. And even though the last time they did it, about two or three years ago, my understanding is that it cost them more to buy the software than they saved in terms of reduction of GPs' prescribing costs. They're doing it again, probably because they've been told to do it. And when this message flashes up on the screen that, you know, if you prescribe X instead of Y, you'll save 24p, and the patient sees that, they are not stupid. And to me, it's incumbent to explain to them that the PCT have done this, why it's there, and also to explain to them that I think it is entirely unethical myself.

Two solutions were presented in the data to the problem of being blamed for poorly-made or simply unpopular rationing decisions. In the first instance, GPs might husband resources covertly or implicitly – perform rationing without publically admitting to it. The other would be for GPs to abdicate all responsibility for resource allocation. Dr U raised the idea of covert rationing:

Dr U: ...We are expected to ration without it being obvious...

Dr U's somewhat sceptical suggestion was that GPs might ration covertly. Covert rationing is not a widespread concept in the general practice literature. Where it occurs it is attributed to governments rather than individual clinicians (Fears et al., 2000). but one that nonetheless some GPs are aware of, as Peter Toon outlined in a public debate at the Royal Society of Medicine (Toon, 2012).

The RCGP guidance used the valued word 'justify', which is a recognition that it's not just an empirical but an ethical judgement we make in our consulting rooms. And much of the time it's impossible to separate the two elements because they involved unconscious processes as well as conscious deliberation. Because these are decisions that are often small, 'should we do this test, should we arrange this referral?' and their evaluative element is often less than the factual uncertainty that we're facing. We can pretend this isn't rationing. That this is self deception. Unless we deliberately disregard the costs of our actions, which can't be just or prudent, we must ration. And the benefits of GP involvement in commissioning, which I've begun to see already is an end to this fooling ourselves. People are beginning to assess the costs and benefits of their judgements, more consciously and explicitly than they did formerly (Toon, 2012).

Toon, unlike Dr U, suggests that covert rationing is more a process of self-deception than a conscious attempt to covertly restrict services in order to preserve healthcare resources. There

are few arguments that implicit or covert rationing is a good idea. Hall (1994) outlines the key argument:

Internalizing cost constraints is a more socially and professionally acceptable means of rationing and, in any event, it is inevitable since even a preponderance of rule-based rationing will leave considerable areas of discretion for physician judgment in the implementation and interpretation of the rules (Hall, 1994).

The problem with abdication of all responsibility for resource allocation is implicit in the above complaints that GPs make about others' rationing decisions. In the quotation below Dr U implies that managers may lack a sense of context when making such decisions.

Dr U: Except we know that managers, can manage, but they don't understand medicine ... of course you brought to the practice administrator to function and manage the administration of the staff, but the actual policy and strategy was done by the partners, not the manager. That's where we've been for the past thirty years.

I did encounter from participants the idea that GPs should be involved in the allocation of healthcare resources. The implication is that managers, without this influence, will make decisions based on economic and other considerations that are somehow divorced from clinical need and knowledge of local need or individual patient circumstances.

Substantive issues and ethics education

Caught between the task and the vocation

The idea of GPs having to prioritise between carrying out tasks generated by the QOF and responding to individual patient's ideas concerns and expectations echoes an issue which I often encounter in medical students. Medical students learn about disease by obtaining data from patients (taking a history) and then presenting the data back to their teachers. However, as they progress towards independent practice, taking a history should become more shaped by the patient's values and agenda, on the basis that that the doctor is there to help the patient. When medical students forget this and prioritise the task (history taking) over the broader aims of talking to the patient, this hinders a humane discourse between the student and the patient. I have thus far refrained from including data in chapter conclusions but there was a relevant piece of data that fits with this observation. Dr E, who supervised both medical students and GP-trainees, illustrated how tasks can override ethical practice.

Dr E: ...in ethics obviously you do get to know quite a lot about how medical students and registrars think, from looking at ...by their behaviour in a very general way sometimes. I had a particularly high proportion of patients with psychological illness, and always make a point of saying, particularly to younger medical students, but also sometimes with registrars – 'that if you've got an exercise to do for an assessment in taking a history from a psychiatric patient, then from my point of view, I want you to be very sensitive to that patient's needs. And I don't want,' and I usually say, 'I don't want you to go like a bull at a gate just to get the data that's on the proforma that you need for the teaching exercise. You know... respond to the patient.' And on several occasions I've had students who have, in spite of being told not to do it, have given their

priority to the exercise and made certain patients very upset, and some occasions, cry. And on one occasion complained about the way the student handled them.

There are morally relevant parallels between the data gathered by medical students in a 'medical history' and the data gathering for the QOF. 'Taking a history' can become an end in itself rather than a means to finding out what is ailing the patient. Students that are too focussed on obtaining the pieces of information that the doctor considers to be important can fail to elicit what patient's relevant ideas, concerns and expectations are. Like the history taking exercise the QOF is only a means to an end. Should the QOF result in a patient's needs not being met, a patient's distress being increased, or an old and frail patient being put at undue risk of side-effects, then it represents an ethical failure of the GP. The GP's belief in whether the incentivised task is worthwhile or even harmful is an ethically relevant factor, and I will discuss this further in the concluding chapter. Even without the element of financial incentives, there is still an ethical balance to be struck between tasks for the benefit of population health, tasks that are measurable and have measurable outcomes, and patient need as expressed by patients and witnessed by GPs.

Ethics education has a potential role in the prevention of financial incentives becoming ends in themselves. Rules for conduct have since pre-Hippocratic times, protected patients from healers' self interest. Authors such as Iliffe call for 'Rules for action' in preference to theory (Iliffe, 2001). Some simple rules on financial incentives that could be extracted from the 'commonsense' insights of my participants might look like the list below:

1. Not allowing incentivised services to compromise duties that are not incentivised;
2. Conscientiously objecting to incentives that are contrary to sound medical evidence (if medical evidence is applicable);

3. If patient-centeredness really is a core feature of general practice then GPs who claim to be patient centred-ought to prioritise this above financial incentives.

The discussion around payment for performance incentives (incentivised tasks) should not be separated from the general discussion of GP's interests as employers, employees and citizens who themselves need to make a living from their vocation. Without professional ethics, any system of payment for GP services can result in maximisation of income in preference to patient welfare as Roland illustrates in the following table (Roland, 2012).

Payment method		What doctors would do if they did not behave in line with their professional principles
Salary	Pay independent of workload or quality	As little as possible for as few people as possible
Capitation	Pay according to the number of people on a doctor's list	As little as possible for as many people as possible
Fee for service	Pay for individual items of care	As much as possible, whether or not it helped the patient
Pay for performance	Pay for meeting quality targets	A limited range of commendable tasks, but nothing else

The element of finance may well add pressure to complete the incentivised task, however. The income that practices receive is expected to provide for staff premises and equipment. GP partners do not earn a fixed salary but have to pay themselves out of the surplus. Toon notes the dissonance between the plethora of literature on making a success of general practice as a business and the literature emerging from journals and the RCGP (Toon, 1994a). He suggests that academic scholarship predominantly treats doctors as platonic gentlemen of independent means, whose sole concern is to decide morally and empirically how best to occupy their time. Clearly this view is a caricature, but the social study of ethics in general practice can offer a bridge between abstract ideals and reality. The ethic of patient-centeredness is a core feature of GP training – but preparation for how this ethic will be tested in practice seems far less core. Ethics must serve patients but must also acknowledge the interests of GPs as employees and owners of small businesses.

Which patient shall I make my first concern? Competing ethical principles in the general practice context

Justice and the fair allocation of healthcare resources are a key element in the academic bioethics that has for many decades been taught to medical students. However GPs train in different contexts over time – at a time where resources are plentiful the skills needed to prioritise resources may wither. Consequently resource allocation may represent an area where periodic ethical reorientation is required. Efforts to give GPs ethical tools have been made by professional bodies, for example the ethics toolkit for GP-commissioners produced by the RCGP ethics committee (Oswald and Cox, 2011). However, I had to know it existed in order to look for it, and there is a commitment of time and effort in reading it –as I discussed in

chapter 5, GPs have far less time for reading than medical students. Moreover, there is debate ongoing over how much rationing takes place in the consulting room and at the bedside, with contrasting views that GPs should act in the patients best interests and that availability should be the only constraint and that GPs do and have the discretion to preserve limited healthcare resources.

Ethics education should recognize the beliefs on which resource allocation may be founded. The reduction of waste has been offered as a way to avoid the need for rationing. The term efficiency-saving implies better use of money whereas rationing implies denying patients that which they want or need. Waste reduction offers a partial solution only. At worst belief in waste reduction may be empirically flawed (I do not propose to settle this question here) or may represent an attempt at avoidance of involvement in rationing decisions. Complementary and alternative medicine raises the issue of what GPs are prepared to endorse as effective treatment or waste of resource. Beliefs about the rationale and effectiveness of medicine are important because they are a core element of being a doctor and a GP. My study is certainly not the only one to raise complementary and alternative medicine in the context of resource allocation. Berney et al also found that some GPs were placed in a position where they believed that such treatments were useless, and a drain on resources, but (in this instance) the primary care trust had decided that patient were entitled to be referred for them. In this situation, the ethics talk revolved around conscientious objection, on the basis of a belief that complementary and alternative medicines were harmful or ineffective (Berney et al., 2005). Even evidence-based medicine, however, may be criticised as either inappropriate for, or as improperly applied to, patient-centred care. Based on what a GP believes, they may conscientiously endorse or object to certain kinds of practice – the literature on conscientious objection revolves in a somewhat limited way around religious belief and reproductive medicine (Savulescu, 2006).

In an era of openness and respect for patient autonomy, some way of involving patients in the dialogue over what GPs will and will not provide seems essential. This already surfaces when trainees and MRCGP candidates are assessed on their ability to negotiate patient expectations. There are two elements to discussions around resource. The first is providing reasons why the cheaper effective treatment will be offered first. The other is explaining which treatments are considered effective and why. Both elements can result in disagreement and even the failure of the GP-patient relationship. This failure may involve disagreements about facts or values.

If we accept that rationing of time and resources takes place, whether at the level of the commissioners or the consultation (and this is implicit in the choice of terms like rationing and resource allocation), then GPs need to be prepared to make rationing decisions that are coherent, consistent and just. The strains of practicing patient-centred medicine in a resource-limited environment is well documented, and Iliffe uses the analogy of GPs being between the hammer of utilitarian, population-based medicine and the anvil of deontological, patient-centred medicine (Iliffe, 2001). Given the ethical agony of being in this situation, it is perhaps to be expected that some GPs would like to abdicate from rationing decisions, or to make those decisions covertly. Avoiding rationing decisions can mean that resources are poorly allocated, or that the people who do take on such responsibilities are less familiar with the particular context of local primary care. Covert and implicit decisions avoid external scrutiny and as a result may be both incoherent and inconsistent and therefore unjust.

Chapter 10: Conclusions

Introduction

In this thesis I have attempted to map how ethics education is constructed in, and for, general practice. I have engaged with people who generated academic, educational and trade literature, as well as those who had access to educational materials both for the purposes of teaching and learning in general practice. I used three linked concepts from the sociology of education (curriculum, pedagogy and evaluation) in order to organise my data (Bernstein, 1971). In order to study ethics education in action, I treated ethics as a kind of knowledge with regulatory implications. I began from the initial premise that everyone engaged in the ethics education of GPs, whether as an academic, an educator or a learner is affected by social forces.

An understanding of these social forces can, I suggest, not only help identify processes of, or problems with, the production and enactment of ethical knowledge but may help us adjust for these processes and problems as well. In a manner analogous to how science translates between the laboratory and the bedside I have tried to capture a sense of how ethics translates back and forth between the classroom and the clinic. Such a concept of translational ethics is akin to that coined by Cribb (Cribb, 2010). This concluding chapter explores the question, “What insights can be drawn from this thesis that may usefully influence someone who is connected to ethics education in general practice?” I do this in two ways. Firstly, I draw out some key ideas from each of the main headings under which I grouped data. Secondly, in the final section, I pull the threads together into an overarching conclusion. I argue that general practice ethics can be seen as a form of boundary work, and that ethics education is

illuminated by seeing it in the context of the sociology of knowledge. This thesis may help to provide a more nuanced and reflexive account of ethics education; one with the prospect of improving the ability of doctors to reconcile ethical standards and ideals with the realities of practice.

Curriculum

In this thesis I have argued that a nuanced understanding of how a curriculum develops as well as what it contains can be useful for teachers and learners. This type of educational reflexivity is endorsed in core GP education materials (Riley et al., 2007c).

Postgraduate education of GPs is built on a foundation of undergraduate education, as well as previous postgraduate experience for those whose career paths do not take them directly to general practice. I noted that an (albeit diminishing) proportion of the GPs in practice may have qualified prior to the embedding of ethics education in the undergraduate curricula. I also noted that GPs who qualified in countries with very different cultural values and undergraduate ethics teaching may struggle without some form of ethical reorientation. As such, there is a real danger that a curriculum that relies on a UK-style experience may be inadequate for all GPs. Moreover, the undergraduate curriculum has been heavily influenced by the dilemmas of specialized hospital medicine. This thematic imbalance is something that has been redressed in consensus statements on the undergraduate teaching of medical ethics and law (Stirrat et al., 2010). However, both the inclusion, and the broadening, of undergraduate ethics education may not yet have had a full impact on the majority of the UK general practice workforce.

The RCGP curriculum contained a discrete statement on ethics for the entire time that I was conducting interviews with participants (Slowther et al., 2006b). The statement attempted to introduce a systematic way of understanding values. However, 'Values based practice' appeared to be ignored by both by the RCGP's own curriculum guide (Riley et al., 2007d) and by independent learning materials in comparison to the four principles of biomedical ethics (Naidoo, 2008a). This observation points to the need to review the relationship between curriculum and pedagogy. Putting a new approach onto a curriculum does not automatically imply that educators will understand or be able to teach it. If all other resources offer a competing framework (the four principles), GP trainees can be forgiven for choosing what they know and what they think they will be examined on rather than what is in the curriculum document.

Discrete curriculum statements can have qualities akin to what Bernstein described as collections – highly controlled sets of knowledge with defined content (Bernstein, 1971). The advantage of collections is that it is relatively easy for learners to identify what they need to know in order to pass examinations. However this only works if teachers and learners read the curriculum document. Only a small minority of my participants were familiar with the MRCGP curriculum statement on ethics and values based practice.

I have argued that it is relevant to consider what the criteria of academic success are when thinking about who may legitimately contribute to the ideas that find their way into teaching. My participants suggested that academic rigour in bioethics may render it paradoxically less intelligible to both educators and practitioners. Publication in specialist journals, partly for this reason, was identified with a decreased likelihood that the publication would be read by ordinary GPs. According to Bernstein, to make a subject distinct is to reduce its immediate relevance, rendering it dry and jargon heavy (Bernstein, 1971). An analogy might be that it

should be more like engineering and less like physics, though an understanding of key principles may be common to both.

Both participants and the literature also suggest that the resources, and therefore the interest, in ethics academia largely lie in the discussion of new biomedical technologies and their introduction largely into a hospital setting (Papanikitas and Toon, 2011). This does not prevent academic ethicists being geographically housed in departments of primary care but may deter them from asking theoretical and empirical questions of direct relevance to the primary care workforce and patients. Similarly resources and interest in primary care academia are perceived to focus less on philosophical study and more on research with quantifiable impact on disease and patient welfare.

One major problem is that there are a number of key factors that mitigate against available and accessible curricular and pedagogic resources for postgraduate trainees in general practice. In particular I have highlighted the following factors: the dominance of a limited model of academic success in ethics, namely philosophical and academic rigour; the nature of resource-allocation in academia which means that ethics resources are often in 'silos'; and the loss of ethics as an identified undergraduate educational role of the academic department of primary care. These are just some of the examples of the ways in which deeper social forces shape ethics education and also determine such things as which topics will be funded, and what kinds of research interest will be accommodated in an academic department.

Pedagogy

Just as education should be more broadly viewed than classroom-activities which focus on a specific subject or qualification (Gewirtz and Cribb, 2009a), I have considered the ethics education of GPs in a way that is purposefully broad. Ethics education may begin with the values inculcated in childhood, and this was hinted at in the trainee focus group. However my remit was to specifically look at ethics education of GPs as GPs, with a consequent emphasis on medical ethics. The span of education that I considered began with a consideration of ethics education in preparation for medical school interviews and included experiences of ethics education at medical school and as a junior doctor as well as the specific ethics education of GP trainees. I also considered education beyond qualification as a GP.

Although participants who were recent UK graduates made halting references to the four principles, those who had qualified outside Europe discussed the difference that they perceived between the local culture and values and those in the contexts in which they qualified. The local graduates appeared to both understand concepts such as patient autonomy and confidentiality and to reflect it subconsciously in discussion and practice. Whether or not local graduates are encultured with these values or get them from ethics teaching, additional help may be required by international medical graduates who are entering general practice in the UK – as the knowledge differences may be more prominent as regards ethics, especially in general practice.

Participant accounts of ethics education between medical qualification and GP-training were few and brief, either stating that there was none, or that what there was focussed on procedural aspects such as keeping patient record confidential. This chimes with ethicists such as Sokol being invited to give an hour's teaching to first-year doctors (Sokol, 2010b). This may

mean that newly-qualified doctors are reliant on their undergraduate education in ethics to make sense of the morally challenging aspects of practice. Undergraduate medical ethics might thus be seen as some degree of immunization against the more harmful aspects of the hidden curriculum both inside and outside of medical school (Cribb and Bignold, 1999).

The formalised provision of ethics education for GP trainees in a classroom setting clearly predates the new MRCGP and the curriculum statement on ethics and values based practice. Where GP training schemes provide a class on ethics this is usually one half-day session comprising a presentation and some discussion. Otherwise, trainees can cover this with their trainer, in discussion with colleagues and through self directed learning. Learning, however, was focussed towards examinations, and participants were not very forthcoming about what they learned, except to refer to the four principles. Participants reflected how easy it was to miss the session on ethics, and how unprepared they were for the ethical aspects of practice. The participants that were not ethics enthusiasts confessed that they did not read books on ethics or look at online guidance, but only got as far as the GMC's duties of a doctor and the four principles.

Regardless of participants complaints about ethics in their formal educational settings, there were two aspects that were described in a universally positive way. Firstly, however little, there *was* some time that was allocated to reflecting on or finding out about ethics. Secondly the classroom environment or trainee group was described as safe. In the formal educational setting, mistakes and misunderstandings about ethics did not have the same perceived repercussions as they did in the work-place. Moreover, trainees had the safety-net of being supervised by a more experienced trainer who could be approached for advice, and indeed expected to be in a position to give it. This relied on participants having functional training-relationships (none of my participants discussed having had a dysfunctional relationship with their trainer). It also relies on GP-trainers being able to help trainees with the ethical aspects of

practice, or to be able to direct them to resources. The relatively intensive supervision of trainees that can take place in general practice may allow trainers to help trainees to spot ethical issues of which they might have otherwise been unaware. Trainers are more likely to be in the old guard who missed undergraduate ethics education, and may be in a position to compensate for trainees missing the solitary half-day on ethics. Much of the formative course work that I discussed in chapter 6 is also assessed by trainers and may never be seen by an independent assessor. Ethics education for GP-trainers may be therefore more if not as important as for trainees. Role modelling has traditionally been one way in which ethics have been taught, and is an element of GP training. Where trainer and/or trainee have the skills to reflect on ethical aspects of practice, this means that the trainer can openly reflect on her habits and, for example, what makes them good or bad habits, and the trainee can be encouraged to come to an independent conclusion. This avoids ethics being simply, 'Doing as others do,' an approach that plays to the hidden curriculum, especially if others do as they ought not to.

Whilst considering ethics education I asked participants about the education of educators. Reading a book, or attendance on a day's course, was considered sufficient by some GP-trainers. Those who had a broader role such as teaching on Masters level course or directing undergraduate ethics education described a variety of ways in which they developed their knowledge, and this involved obtaining diplomas or degrees in philosophy, ethics and/or law. This is in line with longstanding recommendations that undergraduate and postgraduate ethics should have appropriate training (Gillon, 1987).

Informal formative encounters with ethics did occur outside GP-training and post-qualification. These were described in a haphazard way – ethics 'cropped up' in Balint groups and significant event meetings, conversations over a coffee and 'banter' between salaried GP and the senior partner. The only consistent reason for ethics education other than haphazardly was if it

happened to be a special interest for the GP or if it was mandated by an assessment – the only such assessment for all GPs post qualification is the annual appraisal. Outside the educational environment, time is much more precious.

In line with a broad concept of education, I considered reading as a type of pedagogy. Some participants described reading very high level philosophical treatises and others confessed to not reading anything about ethics. Reading reflected the variety of learning styles that GPs may have. Scholarly literature generally was viewed as being jargon-heavy and dry, and if ethics is to be accessed reliably by GPs as a topic, then it needs to be delivered in a variety of styles. This might for example include embedding ethical ideas in dramatic narratives or offering guidance that is focussed on a common aspect of practice. Potentially it might be offered in a variety of media. The problematic aspect of this is that peer-reviewed specialist journals are considered to be markers of academic success but, paradoxically, they can also be seen as the least helpful to front-line educators or ordinary practitioners.

Evaluation

I considered evaluation in two ways in this thesis. The traditional way in which it is considered is in the context of assessments, and I examined formal assessments that occur along the entire span of a GP's medical career, beginning with entry to medical school, and including assessments that might take place after full qualification. I also considered the enactment of ethics in practice as a form of evaluation.

Formal Assessment

Ethics is a knowledge set that many of my participants vividly connected with some kind of formal assessment during their careers. It is assessed at entry into medical school, in medical school examinations, and is an element of selection to becoming Formal assessment of educational knowledge is a phenomenon that Bernstein categorised as a form of 'evaluation.' In essence it is one way in which ethics is enacted, albeit an artificial one. I explored key evaluative encounters represented by formal assessment processes. Just as with 'Pedagogy' (above) participants' accounts included more than just the qualification to become a GP. In a similar fashion to my discussion of pedagogy, I expanded the gaze of the chapter beyond participants' accounts to include selection for medical school and selection for general practice as well as medical and general practice examinations. Participants also connected ethics with formal assessments in practice that were unconnected to career advancement, such as appraisal for revalidation and external scrutiny connected to allegations of malpractice.

Ethics in formal assessments that were connected to career advancement was experienced in two broad ways. It was either: a minor component of a curriculum that would count very little to the total overall mark or it was a small but critical component that might make the difference between success and failure.

Where ethics is a small component of an examination whose absence may be compensated for by different kinds of knowledge in order to qualify, then candidates may view it as something that is negotiable – something that may be deferred, or muddled through. This message comes across from about 'just having to touch' on ethics in the context of preparation for the new MRCGP. Both medical school and the new MRCGP written examinations rely on questions with right and best answers. Ethics may be omitted entirely by the learner at very little risk to

examination success. Where ethics is included in exam revision, its scope may be restricted to learning about questions with definite answers. Essay and short answer questions, where they occur, can be subject to the same kinds of thinking by examinees. The various ways in which ethics as an educational topic is transmitted may be inextricably connected with the way in which it is assessed. Evidence of this among participants was that trainees not only wanted to know things that could be tested but specifically the kinds of things (e.g. facts about current legal opinions) that could be tested by certain kinds of exam (e.g. multiple-choice questions). Similarly participants referred to studying the GMC guidance booklets as this represented the most authoritative set of rules for professional behaviour.

Ethics is potentially unavoidable in assessments, and could make the difference between passing and failing. This is evident in three key ways: Ethics as encountered in interviews and oral examinations, ethics as a compulsory element in coursework, and ethics as a pervasive element in clinical examinations.

The advantage of interviews and oral examinations is that ideas can be explored and tested. However, this can be interpreted as a request to reproduce a model answer. This is evident in discussions about 'The four principles,' in the context of the old MRCGP oral examination. It seems intuitive that if an examiner asks candidates what ethical framework they use, candidates will offer the framework that they think is most widely approved of. They may do so at a very abstract and superficial level because they have not considered how the four principles (or any other ethical framework) work in practice or in what circumstances they may not do so.

Ethics as a compulsory element of coursework has the advantages of putting time for reflection on the learner's agenda, and allows for GP trainees' ideas to be examined by GP-trainers in a way that allows the process to be educational. This process is put at risk when learners prioritise the task above its purpose, for example by striving to get the right number

of ethical cases into an e-portfolio rather than using reading and clinical experience to demonstrate learning in this area. This phenomenon also begs the question of what is an ethical case and how it ought to be analysed. A narrow reading of what counts as ethics may restrict entries to a small number of clinical topics such as abortion or assisted suicide, or to dilemmas rather than everyday practice. As with other types of assessment, candidates may prefer a widely available ethical framework that is on the face of it easy to apply. The worked example for iMAP reflection uses the four principles (RCGP, 2010, RCGP, 2012) and I saw no alternative frameworks offered. Worked examples could demonstrate how to see the ethics in the ordinary as well as the extraordinary consultation. They could demonstrate a range of possible approaches to analysis. Perhaps then examiners might see a more diverse and robust set of answers and candidates might feel less afraid to offer a realistic critique of how the ethics of the classroom meet those of the clinic.

The third way in which ethics can be critical in formal assessments is as a pervasive element in practice. This can be explicitly tested in clinical examinations, whether in medical school or in the new MRCGP. It may also be a way in which a candidate shows repeated deficiency. For example, repeatedly failing to give patients any explanations or options for treatment could be both recognised and remediated by an understanding of respect for patient autonomy. This is illustrated by the plight of many international medical graduates who do less well at the CSA in the new MRCGP. Ethics education, if successful may help such candidates understand the diverse values of the society in which they expect to practice. It may not be enough to assume that such ideas are absorbed over the course of training through role-modelling.

Formal assessment of ethics can also take place outside the examination setting, and two examples of this were in my data: appraisal for revalidation and professional scrutiny over allegations of malpractice. Appraisal for revalidation has the potential to place ethical reflection on GPs lifelong educational agenda. However, truly reflective conversations about

clinical practice may be inhibited by the idea that appraisers have an explicit summative duty. As I encountered among both potential participants in the trade literature, this inhibition may be linked to a fear of sanctions. Where there is a threat of being deemed to be unprofessional, academic notions of ethics give way to a mixture of ordinary language, the law and the GMC duties as outlined in 'Good Medical Practice'. The one potential participant who had been suspended by the GMC declined to offer any explanation (as was his/her right). The potential damage to GPs reputations may inhibit their sharing of lessons learned from such encounters. Indemnity organisations and the GMC get around this problem by publishing paradigm cases that are anonymous. Naturally GPs strive to avoid being subject to fitness to practice proceedings by their regulator.

Practice

Recognition of ethical issues

An idea that emerges clearly from my participant data is that certain clinical scenarios come pre-identified as problematic, needing more careful attention, with the possibility of doing the wrong thing. This pre-labelling of ethics comes largely from medical education. As ethics education appears largely to be an undergraduate phenomenon for GPs then such issues may reflect undergraduate teaching emphases. Issues such as abortion and euthanasia are raised as ethical, as well as a range of situations that might be classed as dilemmas and conflicts. Identification by pre-labelled scenario is useful in flagging certain situations as worthy of more careful consideration. However it may also blinker GPs concerning situations that do not come pre-labelled, or have yet to find their way from the academic and trade literature into formal education.

Another key way in which the ethical content of practice may be identified is through the emotional discomfort that it engenders in the GP. Ethical discomfort is well recognised in educational literature. Despite this, it is not obvious as to what a GP should do about such

discomfort, or that the discomfort is easily identifiable as an ethical problem. This may be one reason why ethical issues are sometimes raised in Balint Groups, one of the safer situations in which GP discuss the interpersonal aspects of practice.

The identification of any aspect of practice as ethical allows the use of analytical tools, and permits access to ethical support and resources. Problematic or distressing issues that are not identified by the person experiencing them as ethical can only be identified as such if they are able to seek non-specific help such as from a GP-trainer or a Balint group. Accordingly GP-trainers, Balint-group leaders, mentors, appraisers and other types of supervisor ought to be able to recognise when a disclosed problem is ethical in nature and at the least to signpost their trainees and colleagues to appropriate support and of resources.

Ethical strategies

The ability to identify an ethical problem, and even to frame and classify it without the knowledge of how to deal with it may be a source of distress for GPs. In discussion, participants identified a number of strategies for dealing with ethical issues.

I was surprised by the honesty with which avoidance was identified as an ethical strategy.

There are many reasons for GPs to avoid becoming involved in ethical decision-making. The GP may not feel that they have sufficient knowledge or experience to deal with an ethically complex case. Ethical decision-making also takes time when time is a precious resource.

Spending the time to deal with an issue can result in increased work for other GPs. Ethical decision-making can produce results that are unpopular or result in criticism of a GP.

Consultations which involve ethical content can be emotionally charged, difficult to deal with and tiring. Accordingly, participants discussed a number of ways of avoiding having to do ethical work. One such systematic avoidance is represented by the delegation of discussions

around abortion to services outside the GP surgery. However a more subtle kind of avoidance is to restrict conversations to the biomedical aspects of practice – measuring physiological values and offering medications whilst disengaging from the holistic approach that is supposedly characteristic of the profession. Avoidance of ethical issues was seen as a morally inferior approach by my participants. Consultations informed by ethical awareness were seen as harder, but better.

The key ethical strategy described by participants appears to be deferral, particularly to rules. Ethical rules, guidelines and policies are all examples of preventative ethics. Based on the idea that people with authority and expertise have produced rules with which to navigate problematic issues, GPs might defer to those rules rather than agonise over every case. Moreover, following rules is a perceived method of exculpation from wrongdoing. Participants also deferred to senior colleagues and to experts, whether they sought advice on what to do or validation of a proposed course of action. Even so some participants qualified their deferral and expressed a reluctance to defer blindly to rules and people.

Conscious engagement with the ethics of practice by reference to ethical theory was described as a minority sport. This begs the question of what is the purpose of ethics education and what are the ethical competencies that ought to be expected of GPs. Participants offered the possible, albeit relatively minimal, answers that ethics might assist with the understanding of the professional boundaries of practice, and might allow GPs to explain their professional obligations to patients. Conscious engagement can be contrasted with a more intuitive, embedded approaches to ethics. The problem with embedded ethics, which I discussed as a form of unconscious competence, is that unreflective practice may either be eroded by the pressures of daily life or fail to change with societal norms – in either case this may entail ethical unconscious competence developing into unconscious incompetence.

The variety of approaches to engagement with ethics both in education and practice may reflect the variety of GP's learning styles. Ethics education needs to be presented in a variety of ways to accomodate this.

Substantive ethical issues

In the two chapters on substantive ethical issues I focussed on key ethical issues that participants discussed, and here I draw together some theoretical threads that might feed back into ethics education.

More than anything else, the participants wanted to discuss confidentiality. The point that comes across very clearly is that GPs are most comfortable staying within the boundaries of their professional rules. Confidentiality represents more than a rule, however. It is a professional ethic that permeates the history of the profession and one which the profession is constantly promising to uphold. The closeness of clinical and professional relationships and the very geographical proximity of practice staff to patients (and their communities) warrants many learning materials having a chapter on ethics *and* a chapter on confidentiality. Justified breaches of confidentiality were still uncomfortable experiences, and the reason for this was that GPs were aware that even when justified, breaching confidentiality carried a risk of harm to the patient or criticism of the GP. Conversely participants described how in confidentiality scenarios, rules could not always be relied upon to give clear answers and required interpretation. Even if there was guidance for a situation there was no guarantee that GPs would know that it existed or how to access it, or, in the heat of a situation, that there would be time to do so. This was a potent source of anxiety. A richer understanding of ethics allows GPs to weigh competing duties, and to understand the basis of confidentiality sufficiently to know when they were in keeping with sprit of the ethic and to recognise when they were not. Of course understanding ethical principles, and their complexities, may not be enough to enact

them; especially where this is connected to a fear of reprisals that overwhelms the courage to do what is ethically right.

One of the sources of ethical tension that arose in my discussions about the key substantive themes was not so much ethical as epistemological. Belief and conscientious objection is something that GP-education materials tend to ascribe to the rights of GPs with conservative religious beliefs to exempt themselves from involvement in abortions. However the ethical education of any GP ought if possible to encompass an approach to dealing with a wide variety of differences in both cultural and scientific belief. These differences may be manifest between the GP and the patient, between different GPs, or even between GPs and the government of the day. Recognising the nature of these differences might sometimes involve making a decision to compromise one's own beliefs in the interest of patient satisfaction or democracy. However it may also involve a sincere conscientious objection, for example, to performing a financially incentivised task, or to making a referral for a treatment that the GP believes is useless or harmful but that the patient has some entitlement to.

As well as conscientious objection, the ethics of conscientious persuasion could be further explored in ethics education and research. The degree to which GPs using their authority and knowledge to influence patients can represent a challenge to the respect for patient autonomy (Doyal, 1999, Neighbour, 2005a). Part of the ethical complexity lies in the acknowledgement and declaration of conflicts of interest. Should the GP who recommends a treatment also state that they have a financial interest in prescribing it, and should the GP who does not believe that a request for abortion meets the criteria set down by law also declare that they are opposed to the procedure on religious grounds? Such disclosures may have a bearing on the outcome of the conversation in themselves, and how to bring ethics into discussion with patients was raised several times in my data.

The discussions surrounding incentivised medicine and around resource allocation illustrate a tension between practicing personalised medicine and population medicine. The strains of practicing patient-centred medicine in a resource-limited environment is well documented, and Iliffe uses the analogy of GPs being between the hammer of utilitarian, population-based medicine and the anvil of deontological, patient-centred medicine (Iliffe, 2001). The educational implication is that ethics education often focuses on the 'individual' account, whether this is informed by a Hippocratic approach, the individualistic aspect of the four principles (where autonomy is first among equals), of the RCGP-espoused ethic of holistic patient-centred medicine. Consequently other accounts may be seen less as ethical and more as the inconvenient facts of life. An awareness of the ethics and philosophy, however basic, of utilitarian aspects of public health, evidence based medicine and concepts of community and solidarity may help GPs to understand their wider duties and the challenge of reconciling these with person-centred practice.

General practice ethics as boundary-work

In this final section I will attempt to draw some overarching conclusions about the production, transmission and enactment of ethics education. In brief I want to argue that general practice ethics can usefully be understood as a complex form of 'boundary work'. It arises at the conjunction of, and from interactions between, many academic and professional currents and debates that determine the boundary of what counts as ethics for different purposes. General practice ethics draws upon, and generates, ideas about both academic ethics and professional ethics. Unsurprisingly given the many different conceptions of, and perspectives in, ethics the various boundaries in question are strongly contested. But these contests are also practically very important because they coincide with crucial concerns about the professional status and legitimacy of general practice as a field and GPs as individual professionals.

Ethics education in any professional setting represents a unique site to study the connections between the production, transmission and enactment of knowledge. This is because ethics is recognised as an overtly contested kind of knowledge, where multiple stakeholders make claims on what a curriculum should contain and who should legitimately contribute to it. Others have raised the possibility that the production and enactment of ethics is significantly shaped by social factors (Cribb, 2010), and I have extended this argument by shining a light on these processes of production in general practice.

In several places in this thesis I have used 'boundary work' (Gieryn, 1983, Gieryn, 1999) as a sensitising concept. Boundary work has been used in the sociology of scientific knowledge and in the sociology of professions to understand how academics and professionals defend their professional autonomy (Wainwright et al., 2006). If curriculum is defined as what counts as valid knowledge for the purpose of general practice ethics, then this is clearly also founded on the ways in which general practice attempts to justify itself among a variety of medical

specialities – chief among these is the claim to be both biomedical and psychosocial. This latter claim contains an important tension which acts on practitioners and can generate broader tensions both within the medical profession and with the demands for clear disciplinary boundaries and constructions of rigour emerging from academia. The tensions between biomedical and psychosocial orientations, as well as those between academic and practical perspectives, need to be systematically borne in mind in the delivery of ethics education to GPs at every stage of their educational journey.

Linked to the contested nature of the ethics curriculum are the questions, “who should own and do GP ethics?” and “what are the implications of different ways of answering this question?” Ethics can be taught differently depending on the learner’s need. There is, of course, a basic need to act rightly, and in a manner that is thereby shielded from criticism. There is an allied need to be able to explain one’s actions, whether to a regulator, a peer or a patient. A key idea that surfaces both in reading and in discussions with participants is whether there should be some deliberate limitations on the ethics education of GPs. Should, for example, the ethical education of GPs (and doctors in general) be limited to the key legislation and professional guidelines? Should all tough decisions be deferred to a GP with special interest in ethics and law or an ‘ethics consultant’? One of the answers suggested by this thesis is that all GPs need to engage with ethics in some greater way (than the above minimum) in order properly to belong in the professional group. In part this is because having a set of ethical standards and, importantly, being able to interpret and balance them in practice is a key demand within, and element of, professional identity. It is, for example, a demand that is potentially present in formal assessments at every key point in a GPs career. In this regard engagement with ethics is part of becoming a GP.

In addition ethics is an unavoidable element of practice. The predicament for practising GPs is that there is often a reality gap between what is expected of them and what the constraints of

practice allow them to do. This too makes some basic engagement with ethics unavoidable. Educators need a better understanding of the GP's predicament as a moral agent. Ethics, by definition, involves answering questions about what is good and bad, right and wrong, professional and unprofessional. Becoming a GP is easier than being a GP in this regard, because it is easier to give the idealistic answer in an examination setting or to talk in abstractions. Admitting to grey areas is difficult for professions and professionals. At first glance, the deliberate removal of 'too much' discussion of ethics from public contexts (from display) avoids revealing weaknesses and inconsistencies in broadly accepted ethical ideas, legislation and local policies. However, preaching what is impossible to practice, and preaching what is not commonly practiced creates un-resolvable ethical tensions for those who have to enact that practice.

Just as a goal for learners is to pass formal assessments and become accredited with the social benefits of the education, there is a sense that practicing ethically means practicing what is either mandated by rule or guideline, or in some way praiseworthy or 'good'. The absence of uniformly uncomplicated decisions in practice means that practitioners run the risk of being considered not good or praiseworthy every time a difficult decision has to be made.

Consequently the demand for ethical knowledge in work may mirror that demanded for exams, in that there is a preference for situational rules rather than an understanding of theory and debate. If a rule is followed correctly it exculpates. However, the same people who demand rules for action will sometimes express dissatisfaction that the smorgasbord of topics and guidelines is not comprehensive or clear enough. Learning a set of rules is not enough – as we have seen in the examples above, rules have exceptions, and rules change over time. Moreover rules are not exhaustive, they require interpretation at some point, and they depend upon sufficient understanding to know when they ought not to apply. Confidentiality is just one clear example of the way that guidelines are not exhaustive or consistent, and GPs

may need to rely on balancing pragmatic judgements and principles when authoritative advice is unavailable. Because an ethic of confidentiality is held in such high regard, even justified breaches of it are associated with discomfort. Acknowledging the existence and the sources of such discomfort may reassure GPs that they are right in thinking that doing the right thing is necessary but also sometimes very difficult.

Hence, as this thesis has revealed, it is important to recognise that because ethics represents professional boundaries, the reflective study of ethics is a dangerous hobby. To be considered unethical is tantamount to being considered unprofessional. GPs will be reluctant to discuss issues that might lead to their own censure. Discussion of such issues also creates dilemmas for colleagues and educators as to whether to interfere or disclose the content of sensitive discussions to a regulator. Whilst no one confided any criminal activities to me, two prospective participants withdrew their consent to participate out of concerns about their privacy and ethical exposure. They highlight a concern that ethical reflection on one's own practice occurs at one's own risk. A genuine amnesty in appraisals may allow GPs to air their ethical difficulties as a first step to solving them. Even a call for a less rhetorical and a more conciliatory tone in response to those dilemmas that are publically aired may encourage more public discussions.

A potentially dangerous implication of understanding ethics as professional boundary work is what I have previously alluded to as an inverse-care issue in ethics education (Papanikitas, 2011a). Professional isolation is not just a matter of geographical isolation. Other empirical work has suggested both that general practitioners and clinicians in primary care access ethics support less, and that better ethics education results in better ability to access such support (Slowther, 2009, Hurst et al., 2007). This may partly be because GPs rightly or wrongly fear professional repercussions by exposing their ethical inadequacies to scrutiny. Factors that affect the approachability of colleagues include elements of safety such (at its most basic)

whether the colleague will be friendly or stern. The failure to access education and support may also be because GPs have developed an unconscious incompetence as regards an ethical matter and are just unaware of the need to reflect on this or to seek advice. Forums and colleagues that have a specified role in looking at broad areas of interpersonal practice or emotional difficulty are uniquely placed to identify ethics (as an educational subject) and signpost GPs to appropriate resources. The simple provision of ethics education resources and ethics support may not be enough – GPs also need an enhanced ability to access both.

Much has been written about academic inter-disciplinarity in the context of ethics research (Dunn et al., 2008). This thesis offers a tentative bridge between the social studies of education and work on general practice ethics. It rests on the premise that, in this translational context, the two fields benefit from being considered side by side. The sociology of knowledge, in particular, has informed my mapping of the phenomenon that is ethics education in general practice. It has helped me understand how ethics as a subject studied is shaped by the sometimes conflicting interests and demands of academia, education and practice. Ethics education needs to draw upon a range of theoretical perspectives but it should also be sensitive to the realities of practice, offering practitioners the tools with which to understand their professional boundaries, and to retain sight of what is good general practice in the grind of daily life with its attendant risk of moral erosion.

Summary of key findings linked to initial research questions

1. What kinds of issues and questions do general practitioners consider are ethical and how are these recognised?

Participants recognised ethical aspects of practice in three overlapping ways:

1. When an issue mapped onto topics that had been pre-identified as ethical, such as confidentiality or abortion.
2. When they identified conflicts between rules or between the needs and perspectives of individuals - including some that were identifiable as 'dilemmas'. E.g. confidentiality dilemmas were illustrated by well described rules that appeared to conflict at times.
3. When emotional discomfort arose that might not be readily explored, classified and resolved without assistance. This could apply to any situation where a GP did not have the skills to identify the source of the discomfort. It could as easily relate to well-rehearsed issues such as confidentiality, or less tangible issues such as power-relationships and professional boundaries. Issues that were not readily identifiable to those experiencing them might be exposed in formal educational settings such as trainee discussions, appraisals and mentoring, or in forums specially aiming to understand areas of difficulty such as significant event audits and Balint groups.

2. How do GPs manage ethical issues in their professional lives?

Participants described three main approaches to ethical encounters in practice:

1. *Avoidance* was one approach to ethics in practice. Difficulty and lack of time were described as predisposing factors to avoidance. This was seen by participants as un-praiseworthy. This was because whilst exploring the ethical aspects of practice might

make decisions harder, avoiding them also involved missing opportunities to improve patient care in a more holistic manner.

2. *Deferral* was perceived to be a common approach to ethical issues; this included deferral to rules and guidelines, a specialist opinion or a senior GP in the workplace. Deferral can involve some abdication of responsibility but it can also increase confidence that a decision (endorsed by guidelines or colleagues) would be either good or less open to criticism.
3. *Engagement* with ethical issues by drawing upon ethical learning and by thinking through the issues and taking responsibility for actions was also reported; but this was not seen as a common approach.

3. How is ethics-education produced for and delivered in General Practice?

The production of ethics as a subject and topic

- Ethics as an educational topic has multiple sources and these include both academic and professional publications.
- Academic rigour in ethics is valued in some publication contexts but may render work less intelligible to both educators and practitioners. Publication in specialist journals, partly for this reason, was identified in the study with a decreased likelihood that the publication would be read by ordinary GPs.
- Professional publications on ethics also face some difficulties of 'translation'. For instance, they tend to emphasise professional ideals and duties, e.g. the professional ethic that celebrates 'Patient-centredness.' This ethic can clash with other sources of practice norms e.g. public health duties or practise that is heavily financially incentivised.

- The building of a strong and cohesive research base in GP ethics faces significant challenges:
- The emphasis on hospital and experimental medicine in academic forums (e.g. conferences and journals) may also deter researchers from asking theoretical and empirical questions of direct relevance to the primary care workforce and patients.
- Ethics research in may be harder to justify compared to research that has obvious or quantifiable impact on disease and patient care.
- In departments of academic general practice/primary care that previously were involved in undergraduate and postgraduate ethics teaching, the loss of this role to other perhaps more specialized departments may contribute to ethics being seen as a low priority field of study.
- Consequently, scholars contributing to this field may find themselves in a diverse array of departments, fields and academic disciplines without easy ways of communicating ideas.

Modes of teaching and learning

- The majority of formal ethics education is perceived to occur at undergraduate level. Formal ethics education is reported to a smaller degree in postgraduate and GP training. Some GPs had sought out additional education but among my participants this was based on personal interest and as part of developing teaching skills and not on clinical need. Some older GPs and international medical graduates may therefore require additional educational input on ethics.
- Participants described classroom-based ethics education in GP training, when it did occur, as brief and potentially easy to miss. They also described discussion, whether in groups, or between trainee and trainer. This may imply an expanded role for GP-

trainers in ethics education, whether as a facilitator of ethical discussion, or as an ethical role model. Consequently, trainers ought to have some training in ethics and an awareness of ethics resources.

- Participants described formal educational settings as safe, with protected time for discussion. This contrasts with descriptions of professional life presenting little time for discussion and isolation from supportive colleagues.
- Participants were aware that ethics education in general practice was guided by a formal curriculum, but for the most part did not know the curriculum's content. Undergraduate ethics education was seen as rooted in academic ethics frameworks such as the four principles, whereas postgraduate ethics education was identified with the GMC's document, 'Good Medical Practice.' For these participants both the 'Four Principles' and 'Good Medical Practice' were learned and taught in preference to 'Value-based practice.' This implies a need to better understand what influences the use of, or ignorance of, key curricular components and models in education.

The testing of ethics

- Participants described preparing for assessment of their ethics education in a limited number of ways, which involved either the 'Four Principles' or 'Good Medical Practice.' Examiners and educators describe these often being used in ways that were abstracted, superficial or rigid.
- Guidance on how to address ethics in coursework or examinations may sometimes appear open to a variety of approaches to ethical analysis. Worked examples, however, generally used the 'Four principles'.
- Formal testing of ethical competence outside of education and training can take place in the contexts of malpractice allegations, significant event audits (e.g. after a complaint), or discussion in a professional appraisal

- The most pervasive test of ethical knowledge is practice itself. Because this is largely unobserved, GPs arguably require skills to appraise their own performance and to find relevant education and support.

4. How do the recognition and management of ethical aspects of practice inter-relate with ethics education in general practice?

- Issues that arise in practice (e.g. through the experience of emotional discomfort or conflicts of needs and perspectives) are not necessarily those that come 'pre-identified' as ethical issues in education.
- Very common approaches taken in practice, including 'avoidance' or 'deferral' approaches, do not all involve the kind of conscious engagement in ethical deliberation often envisaged in ethics education.
- Ethics education is seen as relatively brief and as largely clustering around undergraduate education rather than the contexts in which GPs train and practise.
- The kinds of assessment that occur in ethics education are different in kind from and much less high stakes than the 'assessment' of ethics in practice.
- The genres adopted in ethics texts (especially academic texts) can be alienating to those interested in practical relevance.
- An awareness of the ethical traditions and frameworks that underlie evidence-based medicine, public health, and concepts of community and solidarity, may help GPs to understand their wider duties and the challenge of reconciling these with person-centred practice.
- An awareness of the social forces that shape academic and professional thinking in ethics education may be useful in making arguments for adequate resources for the

study of practice-relevant questions and improved communication between academics, educators, and front-line practitioners.

- This study takes a broad view of ethics education in general practice, pulling together how ethics as a subject for education is conceived, taught and learned, tested in educational and professional settings, and enacted in practice. This represents the study's principal claim to originality.

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Appendices

Please note that some of the forms in the appendices have been adjusted to fit with the required margin specifications for this thesis

Appendix A: Favourable REC opinion



National Research Ethics Service

NRES Committee London - Hampstead

Northwick Park Hospital REC Centre
Level 7, Maternity Block
Northwick Park Hospital
Watford Road
Harrow
Middx HA1 3UJ

Tel: 020 8869 2915
Fax: 020 8869 5222

16 May 2011

Dr Andrew Papanikitas
King's College London
Centre for Biomedicine & Society
6th Floor, Strand Building
King's College London, Strand
WC2R 2LS

Dear Dr Papanikitas

Study title: Making hard moral choices: How do UK general practitioners (GPs) identify, classify and reconcile ethical conflict? (A qualitative study)
REC reference: 09/H0720/126

This study was given a favourable ethical opinion by the Committee on 23 December 2009.

It is a condition of approval by the Research Ethics Committee that the Chief Investigator should submit a progress report for the study 12 months after the date on which the favourable opinion was given, and then annually thereafter. To date, the Committee has not yet received the annual progress report for the study, which was due on 22 December 2010 (Reporting period from 23 December 2009 to 22 December 2010). It would be appreciated if you could complete and submit the report by no later than 22 June 2011.

Guidance on progress reports and a copy of the standard NRES progress report form is available from the National Research Ethics Service website.

The NRES website also provides guidance on declaring the end of the study.

Failure to submit progress reports may lead to the REC reviewing its opinion on the study.

09/H0720/126:	Please quote this number on all correspondence
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Yours sincerely

Mrs Alka Bhayani
Committee Co-ordinator

E-mail: alkabhayani@nhs.net

P.T.O

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

Appendix B: Continuing favourable REC opinion after change of supervision

NHS
National Research Ethics Service
NRES Committee London - Hampstead

Northwick Park Hospital REC Centre
Level 7, Maternity Block
Northwick Park Hospital
Watford Road
Harrow
Middx
HA1 3UJ
Tel: 020 8869 3805
Fax: 020 8869 5222

24 May 2011

Dr Andrew Papanikitas
PhD Student
King's College London
Centre for Biomedicine & Society
6th Floor, Strand Building
King's College London, Strand
WC2R 2LS

Dear Dr Papanikitas

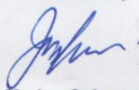
Study title: Making hard moral choices: How do UK general practitioners (GPs) identify, classify and reconcile ethical conflict? (A qualitative study)
REC reference: 09/H0720/126

Thank you for sending the progress report for the above study dated 24 May 2011. The report will be reviewed by the Chair of the Research Ethics Committee, and I will let you know if any further information is requested.

The favourable ethical opinion for the study continues to apply for the duration of the research.

09/H0720/126:	Please quote this number on all correspondence
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Yours sincerely


Mr Jun Sakuma
Assistant Committee Co-ordinator
E-mail: junsakuma@nhs.net

Copy to: Mr Keith Brennan
First Floor
Hodgkin Building
Guy's Campus
King's College London
London
SE1 1UL

This Research Ethics Committee is an advisory committee to London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England

Appendix C: Participant Infosheet



University of London

PARTICIPANT INFORMATION SHEET

Interviews: Stakeholders

Bioethics scholarship and moral deliberation in UK General Practice

Introduction

I would like to invite you to participate in a PhD research project which looks at the combined ethical, social and legal understandings, regulations and practices that inform how UK GPs identify and reconcile ethical conflict in the context of primary care. This information sheet is designed to give you more information on the purpose of the study, and to outline what you would be invited to do if you took part in the research. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information and discuss it with others if you wish. If anything is not clear, or if you would like more information, then please contact the researcher at any time. Please remember that you should only participate if you want to and choosing not to take part will not disadvantage you in any way.

What is the purpose of the research project?

This project will address the questions: What issues generate ethical conflict for GPs? How are these ethical conflicts resolved or reconciled? How does this affect and how is it affected by curricula, guidelines and academic research into law and ethics?

The study (towards a PhD in the Sociology of Biomedical Ethics) aims:

1. To discover, using qualitative methods, the explicit and implicit ethical decision-making strategies used by UK GPs as well as those suggested by stakeholders involved with UK Primary Care Ethics.

2. To use this data to further understand how such decisions are made, why different strategies are used and how moral principles, professional guidelines and laws are applied and reconciled when they conflict.
3. To contrast the approaches used by a sample of UK GPs and relevant stakeholders with ethical frameworks identified in the literature on General Practice ethics.
4. It is anticipated that this research will illustrate different perceptions and strategies of ethical decision-making by UK GPs, and that this will help lawyers and policymakers shape future laws, codes of practice and guidelines for situations associated with ethical dispute, conscientious objection and moral ambiguity.

Who is conducting the research?

The project team consists of Dr Andrew Papanikitas (Centre for Biomedicine & Society, King's College London) who is supervised by Professor Clare Williams (Centre for Biomedicine & Society, King's College London); Professor Steven Wainwright (Centre for Biomedicine & Society, King's College London); with advice from Professor Rosamund Scott (Centre for Medical Law and Ethics, King's College London). The Chief Investigator is Andrew Papanikitas. The research will be carried out by Andrew, who is a part-time practising GP and has had training in Medical Law and Ethics as well as qualitative research methods.

Who is funding the research?

This study is currently self-funded.

What would I be invited to do?

We wish to conduct interviews with GP and non-GP stakeholders in primary care ethics. The interviews will be conducted by Andrew Papanikitas, a practising GP with training in clinical ethics and qualitative research methods, and will last approximately ninety minutes. With permission, interviews will be audio recorded and transcribed.

What are the aims of the interviews?

Discussion about ethical decision-making in Primary Care, which we hope will be useful to everyone participating

- To produce examples of dilemmas and insights into their resolution

- To help frame interview and focus group research which is taking place in parallel to these stakeholder interviews

Possible risks of participation

Some participants may feel anxiety about some of the topics raised, or discomfort with the implications of expressing their views. Topics may be raised, or ways of thinking about them, that you did not anticipate, or would rather not discuss openly. The dilemmas raised may not be resolved in the discussion. You may hold religious, political or cultural beliefs that you do not wish to reveal, or to have to explain.

Possible benefits of participation

GPs at all stages of training are encouraged as part of appraisal and revalidation to reflect upon the ethical problems which may arise in the context of primary care. It is also hoped that all participant stakeholders will have the opportunity to contribute to and influence research findings that may lead to policy recommendations and academic contributions to GP-education and primary care ethics.

Will the information I provide be kept confidential?

In accordance with the 1998 Data Protection Act, all information collected during the research will be kept confidential. Transcripts of the interviews will be anonymised and any identifying details removed. Some broad demographic questions may be asked (e.g. practice setting, qualifications in medical ethics) to aid interpretation. Recordings and transcripts will be stored securely in a research office. At project completion, audio recordings will be destroyed; transcripts will be stored for 7 years from project completion. Consent forms will be kept securely for the same period. If anyone feels, at the time or afterwards, that they do not want specific statements to be used in reports we will omit these from the transcript. However, we cannot withdraw data after it has been included in a submission, presentation or publication (which will take place a minimum 60 days after participation). Please feel free to

emphasise while you are talking if you want particular points to be omitted from all reports. The only exception to this would be the disclosure of unacceptable practice.

What will happen to the results of the research study?

We will publish papers in academic journals and give conference presentations. The results will be presented as a PhD Thesis, which in turn may be published as a book. Verbatim quotes may be used, but participants will not be identifiable in any report, publication or presentation. Participants may elect to receive a summary of findings toward the end of the study, which will be placed on the project website. Further details of the project can be found on the King's College London website at: <http://www.kcl.ac.uk/schools/sspp/interdisciplinary/cbas/phd/ap.html>.

Who has reviewed the study?

This Study has been approved by the Royal Free Hospital NHS Research Ethics Committee (ref. no: 09/H0720/126)

What do I do now?

If you are interested in hearing more about the study then please contact Andrew and he will be happy to answer any questions you may have. If you agree to participate then an interview will be scheduled at a time and place convenient for you. If you do decide to take part you will be asked to sign a consent form and be given a copy of this and the information sheet to keep.

E-mail: andrew.papanikitas@kcl.ac.uk

Telephone: 07872383688

What if I decide not to take part?

You are free to decide not to take part. Even if you do agree to take part you are free to withdraw from the study at any time without explanation. Withdrawal will not be possible once data has been

used in publications (a minimum of 60 days after your participation).

What if I have any concerns?

If you have any concerns or other questions about this study or the way it has been carried out, then please contact Andrew Papanikitas in the first instance.

Alternatively, you can contact Professor Clare Williams, main academic supervisor and Director of the Centre for Biomedicine and Society, King's College London.

E-mail: clare.2.williams@kcl.ac.uk

Telephone: 07850 093522

What if something goes wrong?

If you are harmed by taking part in this project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal NHS complaints mechanisms should also be available to you. Information about Independent Complaints Advocacy Services is available on the webpage:

www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Complaintspolicy/NHScomplaintsprocedures/DH_4087428

Thank you for reading this

Appendix D: Interview consent form

CONSENT FORM

Interviews

Bioethics scholarship and moral deliberation in UK General Practice

Name of Chief Investigator: Dr Andrew Papanikitas

Names of Supervisors: Professor Clare Williams and Professor Steven Wainwright

Name of Interviewer: Dr Andrew Papanikitas

Please initial box

1. I confirm that I have read and understand the information sheet dated ☐
(insert date) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw ☐
specific statements made in the interview or the entire interview, prior to the inclusion of
data in a presentation, publication or submission (which will take place a minimum of 60 days
after my participation), without giving any reason, and without my legal rights being affected.

3. I agree to my interview being recorded on tape/cd/digital recording on the

Understanding that the audio recording will be destroyed/erased once the ☐
project is ended (July 2011).

4. I understand that my interview will inform the study and that data from ☐
this interview may be used anonymously in reports and publications.

I agree to take part in this interview subject to the conditions agreed above:

Name of Participant

Date

Signature

I confirm that I have explained the proposed study to the participant:

Researcher

Date

Signature

One copy for participant; one copy for researcher.

Appendix E: Focus group consent form

CONSENT FORM Discussion Groups

Bioethics scholarship and moral deliberation in UK General Practice

Name of Chief Investigator: Dr Andrew Papanikitas

Names of Supervisors: Professor Clare Williams, Professor Steven Wainwright

Name of Ethics Discussion Group Facilitator: Dr Andrew Papanikitas

Please initial box

1. I confirm that I have read and understand the information sheet dated (insert date) for the above study and have had the opportunity to ask questions.

☐

2. I understand that my participation is voluntary and that I am free to withdraw specific statements made in the discussion, prior to the inclusion of data in a presentation, publication or submission (this will take place a minimum of 60 days after my participation), without giving any reason, and without my legal rights being affected.

☐

4. I agree to my contribution being audio-recorded on tape/cd/digital recording on the understanding that the audio recording will be destroyed/erased once the project is ended (July 2011).

☐

5. I understand that my discussion group will inform the study and that data from this discussion group may be used anonymously in reports and publications.

☐

5. I agree to abide by the confidentiality agreement in the Chatham House Rule.

☐

I agree to take part in this discussion group subject to the conditions agreed above:

_____	_____	_____
Name of Participant	Date	Signature

I confirm that I have explained the proposed study to the participant:

_____	_____	_____
Researcher	Date	Signature

One copy for participant; one copy for researcher.

Appendix F: Interview topic guide

Topic Guide: Stakeholder Interviews

Bioethics scholarship and moral deliberation in UK General Practice

Name of Chief Investigator: Dr Andrew Papanikitas

Names of Supervisors: Professor Clare Williams and Professor Steven Wainwright

Name of Interviewer: Dr Andrew Papanikitas

It is not anticipated that the interview will match these questions exactly or that all of them will be covered, however these are a guide to the core issues relating to the research questions. This topic guide may be modified, based on the stakeholder's background and involvement in primary care ethics.

This research looks at how UK GPs identify, categorise and attempt to reconcile ethical issues which arise in the context of primary care. This study also asks similar questions of certain stakeholders such as your self. I would like to begin by asking some broad background questions:

- How would you describe the setting in which you currently practice? (if not a GP –how would you describe your involvement with General Practice or Medical Ethics?)
- Would you be happy to describe your background in terms of religion or world-view?
- Do you have any expertise or qualifications with regard to medical ethics and law?
- What broad involvement do you have in teaching/designing professional curricula or setting standards which will be used by UK GPs?
- What experience of teaching or learning have you had w.r.t. the RCGP statement on ethics and values based medicine, Good Medical Practice or Medical Ethics and Law more broadly?

I am now going to ask you about how you approach ethical problems in general practice. There are no wrong answers. You may decline to answer any question, withdraw any statement, take a break or stop the interview at any time. At times it may seem as though I am pressing you, but this is only because I am interested in finding out what you think about these issues.

- What kinds of situations do you think of when you hear the phrase, 'Ethical issues in general practice'? How would you distinguish GP ethics from Primary Care ethics?
- Do you think that GP or Primary Care ethics is sufficiently different from hospital ethics to warrant its own subdiscipline of medical ethics? If so why? If not why not?
- How do you feel that the styles and approaches used in bioethics scholarship relate to moral deliberation for UK general practitioners?
- In what ways might ethics curricula, codes of practice and ethical/legal guidelines relate to moral deliberation?
- What do you think makes a problem an ethical problem in General Practice?
- Can you think of an example in your practice or which you are aware of? Would you be happy to discuss this? How did you/would you go about resolving this problem?
- In broad terms how do you/would you approach resolving an ethical problem? Do you use any particular ethical frameworks in practice? Can you give me an example?
- Have you ever had to make a choice between two unacceptable outcomes? Could you tell me more about this and how you resolved the issue?
- Are there any peer support networks you use for such problems? Would you use a clinical ethics committee if one was available? Do you ever use medical defence organisations to aid ethical decision-making? Would you be happy to give me an example?

Appendix G: Focus group topic guide

Topic Guide: Trainers Focus Groups/Trainee Focus Groups

How do UK general practitioners identify and reconcile ethical conflict?

Name of Chief Investigator: Dr Andrew Papanikitas

Names of Supervisors: Professor Clare Williams and Professor Steven Wainwright

Name of Interviewer: Dr Andrew Papanikitas

How do UK general practitioners identify and reconcile ethical conflict?

It is not anticipated that the discussion will match these questions exactly or that all of them will be covered, however these are a guide to the core issues relating to the research questions.

This research looks at how UK GPs identify, categorise and attempt to reconcile ethical dilemmas which arise in the context of primary care.

I would like to begin by asking each participant to write down an answer to these broad background questions which have been shown to be relevant to ethical decision-making in previous research. ***All answers are optional and will be kept confidential from the group so as not to bias discussion in any way. (presented to each participant as a form prior to the discussion -attached):***

- How would you describe the setting in which you currently practice? (e.g. rural, urban, suburban)
- If you are happy to do so, would you describe your background in terms of religion or world-view?
- Do you have any expertise or qualifications with regard to medical ethics and law?
- What broad involvement do you have (if any) in teaching/designing professional curricula or setting standards which will be used by UK GPs?
- What experience of teaching or learning have you had w.r.t. the RCGP statement on ethics and values based medicine, Good Medical Practice or Medical Ethics and Law more broadly?

I am now going to ask you to discuss how you approach ethical problems in general practice. There are no wrong answers. You may decline to answer any question or withdraw any statement, take a break or leave the group at any time in discussion. I will do my best to stay quiet

and leave the discussion to you. This exercise is expected to take roughly ninety minutes, and I will move the group on at certain intervals.

- What kinds of situations do you think of when you hear the phrase, 'Ethical issues in general practice'? What do you think makes a problem an ethical problem in General Practice?
- In broad terms how do you/would you approach resolving an ethical problem? Do you use any particular ethical frameworks in practice? Can you give me an example?
- Can you think of situations where a GP might make a choice between two unacceptable outcomes? Could you tell me how you resolved the issue?
- Can you think of an example of ethical dilemmas in your practice or which you are aware of? Would you be happy to discuss this? How did you/would you go about resolving this problem?
- Are there any peer support networks you might use for such problems? Would you use a clinical ethics committee if one was available? Do you ever use medical defence organisations to aid ethical decision-making?
- How would you describe professional ethics? How is this different from the law? Who should decide what is the right decision?

Appendix H: Acknowledgments

First and foremost I would like to thank all the participants in my study, whose generosity of time and collective insights power this thesis. I would like to thank my supervisors, Professors Alan Cribb and Sharon Gewirtz, as well as my former supervisors, Professors Clare Williams and Steve Wainright. I would like to thank my examiners, Professors Roger Jones and Ed Peile for their thorough appraisal of my work and helpful corrections. I would like to thank all the ethics and primary care scholars who have given me advice on getting started in the field and the nature of doctoral research, especially Mary Hawkey, Anne Slowther, Ed Peile, Annette Braunack-Mayer, Deborah Bowman, John Spicer, Deborah Saltman, Peter Toon, Luke Zander Barbara Painsack, Jonathan Ives and Brian Hurwitz as well as many others. My PhD student and junior research colleagues have also been as source of inspiration, support and three in particular helped me find my feet as a new research student: Rosalind Willis, Anne Laybourne and James Porter. Ian Hill deserves special mention for our long discussions about sampling from and interviewing elite populations and Lea Lahnstein for long-distance discussions about my work pre-viva that were supportive and challenging. My family deserve special acknowledgement, especially my wife, Emma, my parents and my brother who have supported me through this thesis.